DOCUMENT RESUME

ED 324 104 PS 019 056

AUTHOR Romig, Candace L., Ed.
TITLE Family Policy: Recommendations for State Action.
INSTITUTION National Conference of State Legislatures, Denver, CO.
REPORT NO ISBN-1-55516-627-X
PUB DATE Dec 89
NOTE 188p.
AVAILABLE FROM National Conference of State Legislatures, 1560 Broadway, Suite 700, Denver, CO 80202 ($25.00).
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS Agency Cooperation; Family Health; Family Life; *Family Problems; *Family Programs; Financial Support; Fringe Benefits; Government Role; *State Action; State Government; Work Environment
IDENTIFIERS Family Development; Family Life Cycle; *Family Policy; Family Support

ABSTRACT

This publication on family policy reviews federal and state policies and offers recommendations for state action. Initial discussion covers changes in the American family, demographics, and the economy. Issues of family maintenance considered include: family welfare policy and welfare reform; child abuse and neglect; alternatives to out-of-home placement; custody and visitation; child support enforcement; and homelessness and families. Issues of families and the workplace concern: pay equity; child care; family leave; job training and retraining; and youth employment and service. Issues of family support and development through the family life cycle concern: parent education for parents of children from birth to 3 years of age; early childhood education; families and the school system; drop-out prevention; adolescent pregnancy; and informal family caregiving for adult family members. Issues of family health policy concern prevention of low birthweight; the fight against substance abuse and its effects on families; youth suicide; responses to mental health problems; human immunodeficiency virus infection and disease; access to family health care by the medically indigent; and home care for disabled children provided by supporting families. State innovations in coordinating and financing family services are outlined. (RH)

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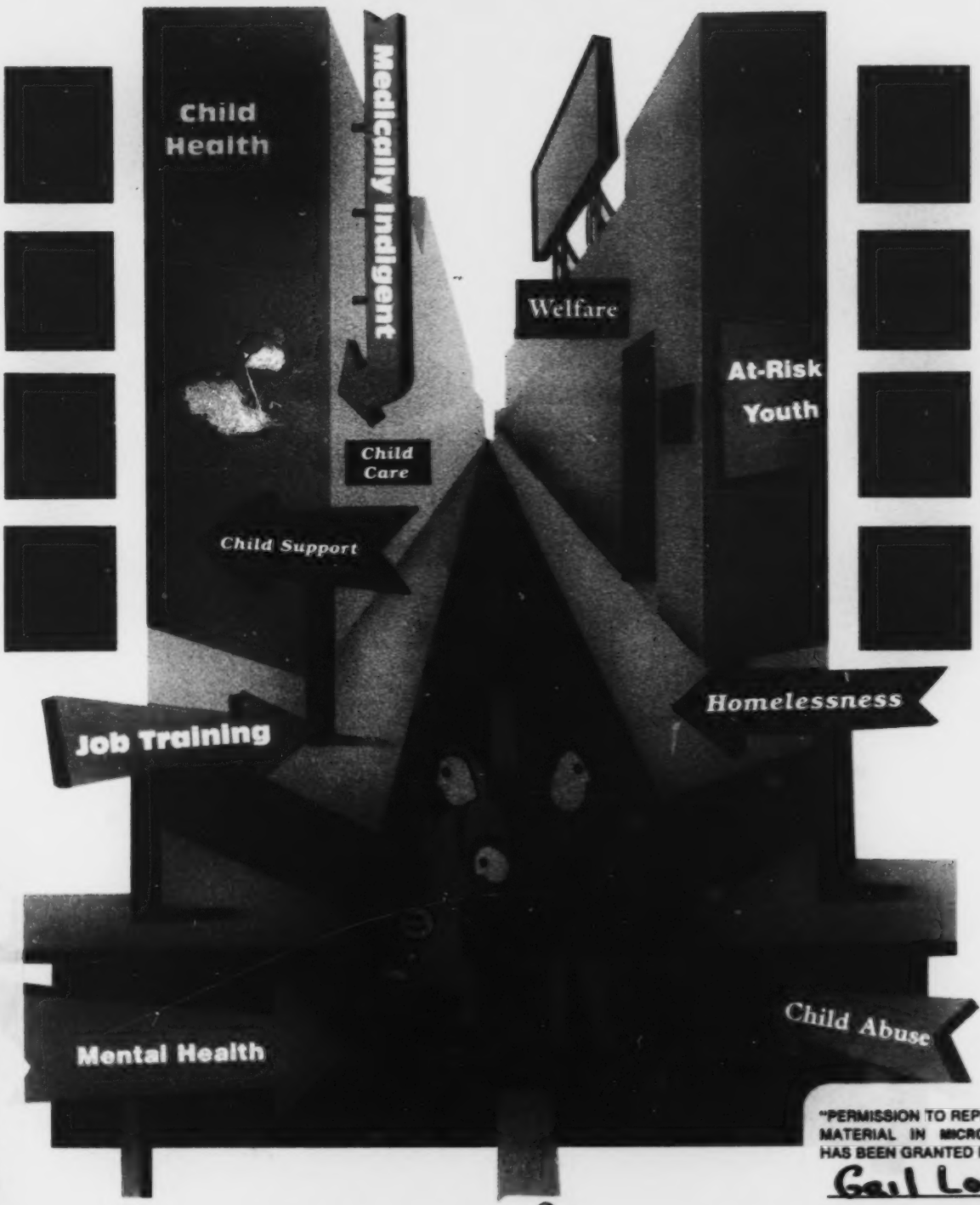

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- To improve the quality and effectiveness of state legislatures;
- To foster interstate communication and cooperation; and
- To ensure states a strong, cohesive voice in the federal system.

The Conference has offices in Denver, Colorado, and Washington, D.C.

FAMILY POLICY:
RECOMMENDATIONS FOR STATE ACTION

by

The Children, Families, and Social Services Committee

edited by
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National Conference of State Legislatures
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December 1989

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ISBN 1-55516-627-X

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ACKNOWLEDGMENTS

This book represents the first project of the Children, Families, and Social Services Committee, which was formed in January 1988 under National Conference of State Legislatures' President Senator Ted Strickland (CO). Two sets of appointees from all 50 state legislatures comprised the committee. Their names are noted under Appendices A and B.

Committee meetings during the last two years have been devoted to the deliberation of the issues outlined in this book. Representative Jane Maroney (DE) deserves special thanks for initiating this project during her tenure as the first chairwoman of the committee, and Assemblyman Albert Vann (NY) warrants special commendation for facilitating the completion of the project during his chairmanship.

The book would not have been possible without the cooperation of the entire Human Services Department staff at NCSL. The staff wrote the chapters for the committee to discuss and rewrote sections as directed by the committee. Human Services staff authors include: Mary Claire Arant, Scott Chazdon, Rebecca Craig, Lorraine Dixon-Jones, Shelda Harden, Tracey Hooker, Martha King, Laura Loyacono, Tommy Neal, Susan Robison, Candace Romig, Catherine Sonnier, and Shelley Smith. For more information, staff contacts are included at the end of each chapter.

In addition, John Myers, Mark Weston, Karen Walker, and David Shreve in the NCSL Education Program assisted with the sections addressing education and job training. Susan Biemesderfer in the NCSL Legislative Management Program drafted the section on substance abuse and Heather Maggard, former policy specialist in the Children, Youth, and Families Program, wrote the sections on adolescent pregnancy and youth suicide. John Agosta, of the Human Services Research Institute, drafted the section on families with disabled children. Senator Charles Bruner (IA) deserves a special thank you for drafting the section on collaboration and financing and for extensively editing many of the sections of the publication.

A thank you is extended to the following NCSL staff for special contributions: staff assistance, coordination, and word processing by Joanne Ourada; and copy editing and production by Sharon Schwoch.

NCSL wishes to thank the A. L. Mailman Foundation and Luba Lynch for their support in editing, publishing, and distributing this document.

The Children, Families, and Social Services Committee and the NCSL Human Services Department assume all responsibility for errors or omissions in this document. The recommendations herein are the sole product of the committee and are not to be construed as an endorsement by NCSL or the A.L. Mailman Foundation.

INTRODUCTION

Background

The Children, Families, and Social Services (CFSS) Committee of the National Conference of State Legislatures (NCSL) has devoted three years to investigating, debating, and drafting these recommendations for state action on family policy. As state legislators and legislative staff, the committee members understand the enormous demands facing states on human services issues, such as: child welfare, adolescent pregnancy, child support enforcement, child care and early childhood education, mental health, long-term care for the elderly, uncompensated health care, health care cost containment, and welfare reform.

State health and human services committees are charged with the resolution of complex and costly human services problems facing the states. But throughout the past 10 years, more of these policy considerations are being undertaken by other committees as well. For instance, education and human services committees are asked to consider legislation on at-risk youth and child care/early childhood education, while child support enforcement bills are considered by judiciary committees as often as by human services committees. To take this one step further, states deliberating a restructuring of systems and services under the rubric "welfare reform" need the cooperation and legislative input from a variety of committees, including health and human services, judiciary, education, business and labor, local government, and appropriations.

In addition, state legislatures are increasingly involved in all aspects of human services. State legislators have responsibility for appropriating funds for new programs; establishing program guidelines; overseeing program outcomes; appropriating federal funds to state human services programs; evaluating the success of programs in meeting the needs of the public; and balancing constituent demands for human services with transportation, education, economic development, and other public policy issues.

The development of comprehensive, cost-effective family policy has been complicated over the past 10 years by the dramatic changes in the American family, the national demographics, and the national and state economies. Add to this scenario the fact that approximately 40 percent of state legislators are new after every two-year election and the critical need for interstate communication and discussion on family policy becomes more apparent. Legislators and legislative staff benefit from experiences in other states. They are eager to see other state legislation, to understand the funding of state programs in relationship to other budget priorities, to learn the evaluation procedures, to share the political difficulties inherent in democratic deliberation of public policy issues, and to know what works and what does not.

Through their discussions, the CFSS Committee members agreed that the development of sound state family policy must be a bipartisan issue. Members were committed to including all issue stakeholders in the development of policies that enable families to provide for the economic, social, and emotional needs of their members. The committee adopted the following definition for *family*: any two people related by birth or marriage living under the same roof. This illustrates the revival of an "extended family" approach to the recommendations for state family policy to include family members from birth to death and the greater responsibility families have for the very old as well as the very young. The committee agreed that all families are valuable; there is no substitute for removing people from poverty to make families more functional; parenting education is important; and government can facilitate opportunities to strengthen all families.

In this spirit, the CFSS Committee believes that this publication serves to:

- Review the progress of state family policy issues over the past decade;
- Provide descriptions of successful and innovative state strategies for family policy development;
- Assist legislators and legislative staff in critically analyzing state family policy issues by raising key points for consideration in the policymaking process; and
- Facilitate a constructive exchange of ideas and concerns that focus on the basic tenets and processes in family policy development.

As a preface to the recommendations for state family policy, this publication reviews the changing American family, the country's changing demography, and the changing economy to establish the context within which family policy issues must be considered. Likewise, the state recommendations are organized under four major topics that illustrate the needs of the modern American family and its changing conditions: family maintenance, families and the workplace, family support and development through the family life cycle, and family health. A final chapter outlines state efforts at collaborating and financing family services.

As in the legislative process, these recommendations have been forged by consensus. CFSS Committee members often have disagreed on the scope and feasibility of certain recommendations, and sometimes individual members have questioned the wisdom of a particular policy option given the political reality of their own states. However, all members were unanimous in confirming the need to encourage and assist states in seeking ways to strengthen families. Realizing the severe problems especially facing the youngest members of American families, the committee believes that ensuring adequate financial, social, and emotional support for them will strengthen the very foundations of our nation.

The Changing American Family

The family is the fundamental social unit, providing for the basic needs of its members and the nurturing and development of each new generation. Although undergoing a radical transformation, the family is unparalleled in its efficiency and success to meet the needs of its members. No institution can replace the family. Its failure would signal the unraveling of the society upon which all institutions are built.

For the past several years, news stories and political opinion polls have abounded describing the demise of the American family. Adults are in general agreement that times are economically, socially, morally, and politically harder for kids today than when they were growing up. While many of us cling to the image of the traditional family, with a breadwinner father and a stay-at-home mother to care for the children, reality indicates an increase in families without fathers, children without families, and families without homes. In their efforts to develop public policy on family issues, lawmakers are confounded by the lack of a common understanding of the modern American family and ways to help it function.

Mothers Working Outside the Home. Perhaps the most dramatic change in the structure of the American family in the 20th century is the number of mothers working outside the home. By 1990, 55 percent of all mothers with children under age six and 75 percent of all mothers with children aged six to 18 are expected to be in the labor force.(7, p. vii) Mothers with children under three now make up the fastest growing segment of the labor market. Poor mothers have always had to work outside

the home to provide additional support for their families, but today all families realize the importance of the mother working for wages to maintain their standard of living. By 1995 two-thirds of all preschool children and four of five school-age children will have mothers in the workforce.(5, p. 175)

Accessible, affordable, quality child care can enable poor parents to move families from dependency to self-sufficiency through education and training programs that lead to employment. However, the country is facing a child care crisis. Even two-income families complain about the lack of affordable child care. Frequently, parents use a conglomeration of child care resources and are forced to leave young children unsupervised or to accept poor-quality, unsafe services. According to a 1986 Census Bureau survey, the average child care cost of $45 per week for the 5.8 million women reporting such payments was 6 percent of their monthly family income. Child care costs of $32 per week paid by women in poverty was 22 percent of their monthly family income.(16, p. 24)

The Impact of Divorce. Divorce has had a dramatic impact on the American family. The 1970s witnessed attempts at divorce reform that backfired. Many divorce reform efforts were based on the assumption that more women in the workforce guaranteed that women could adequately support their young children by themselves. The assumptions did not include the 64 percent discrepancy between women's and men's wages documented in the country, and the reform often resulted in inadequate spousal and child support awards. Many divorced women in the job market were handicapped by years of family caretaking outside the workforce. Research shows that a woman's post-divorce standard of living falls dramatically, while a man's often increases.

Interestingly, the single most influential indicator in poverty seems to be marriage. Marriage and access to two incomes can keep people above the depths of poverty, and poor women often leave public assistance upon marriage. However, young women seem to be raising children outside of marriage at an increasing rate. Unmarried teen parents face harsh economic realities. Half of the tenth-grade young women who became mothers and almost one-third of the tenth-grade young men who became fathers drop out of school.(5, p. 166) Of course, this reduces their ability to be self-sufficient. In fiscal terms, 48 percent of California's 1987 Aid to Families with Dependent Children (AFDC) dollars, or $821 million, went to mothers who first gave birth in their teens.(4, p. 8)

Single-Parent Families. The long-term trend toward increasing numbers of single-parent families represents a major threat to the economic security of America's children. Poverty rates for children in single-parent homes, which are most often headed by women, have averaged approximately 50 percent. Two factors explain this phenomenon: 1) absent parents are not contributing to the support of their children as married parents do; and 2) custodial parents, mostly women, are not earning enough money to care for their families. Men's earnings add an average of $28,000 per year in income for intact families, while child support and alimony add only $1,000 per year on average in single-parent families. In addition, the work and earning patterns of single mothers look much more like wives' than husbands'.

Single mothers are often faced with a choice of working all the time at low-paying jobs or going on welfare. Only if a woman is able to make $6 or $7 per hour, with medical benefits and inexpensive daycare, will she be able to provide for her family better than if she is on welfare.(1, pp. 1051-1052) Both single parents and two-parent families lack social support for the roles they must assume as workers and parents. The United States is distinguished among western nations for its lack of family support policies, such as: subsidized child care, parental leave, flexible work schedules, employment security, and work allowances. These issues affect men and women equally as workers and family members.

Elderly and Disabled Family Members. As the population grows and the financial resources diminish to satisfy all demands for services, the family increasingly will be responsible for the care and support of the elderly and the disabled. Families maintain an informal caregiver system that provides a major percentage of long-term care to their members. According to a 1988 survey, 7 million

households, or 7.8 percent of all American families, contain a caregiver of an elderly person. This caregiver is usually a married woman about 45 years old who works full-time.(10, pp. 7-8) As the population continues to age--the population 85 years and over will double between 1980 and 2000--the demand for long-term care services will increase. Many of the "young" old (ages 60 to 75 years) will be needing special services at the same time that their resources are being tapped to care for their older parents.

Currently, the nation is struggling with the aftermath of deinstitutionalization and the lack of resources in the community to care for the mentally ill, the developmentally disabled, and other handicapped persons. One of the crucial factors in the solution's equation is the family and the role that it can play in providing home-based services, directing humane cost-effective policies, and evaluating the success of services to meet the needs of individuals. As more emotional and financial resources are demanded of families to balance the care, development, and nurturing of the young with the care and support of the elderly, while being independent, self-supporting, contributing community members, policies will be needed to provide respite care and support for their many activities.

The Changing Economy

The need for two incomes to support today's families is not just a matter of perception or demands of lifestyle. Family income and wages earned by male workers have steadily declined, and female-headed households have steadily increased. Real family income has fallen 8.3 percent since 1973, despite the rising number of two paychecks in the family. Families with children watched their share of national income decrease 20 percent between 1973 and 1984. Workers' real earnings have dropped 10 percent since 1979. The U.S. Select Committee on Children, Youth, and Families reported that 35 percent more two-parent families would live below the poverty line if wives were not employed.(4, p. 18)

Economic change has had a dramatic effect on families headed by men. For instance, a middle-income man turning 40 in 1963 saw his real income climb 30 percent by the time he turned 50. The same man turning 40 in 1973 could expect his real income to fall 14 percent in the next 10-year period.(4, p. 18) Unemployment rates of 3 or 4 percent were common in the 1950s and 1960s, while the normal rate is now accepted at about 7 percent. However, this figure does not include the many people who have stopped looking for employment or the growing numbers of people who are underemployed or work part-time jobs without adequate benefits or incomes to support families.

Displaced Workers. The transition from a manufacturing to a post-industrial economy is part of the reason for the dislocation of 11 million workers between 1979 and 1984. The Bureau of Labor Statistics surveyed 5.1 million displaced workers who had become unemployed in this period. One-third were still unemployed in 1986. Of the 3.4 million who had found new work, 44 percent were making lower wages. Sixty percent of these had no health insurance.

Economists disagree about the long-term implications of the service-information economy on wages. But in the short term, it is clear that workers can expect to command much lower wages than they could in the troubled manufacturing sector. Service sector workers earn 51 percent of what manufacturing workers do. The congressional Joint Economic Committee reported in 1987 that 60 percent of the jobs created since 1979 paid less than $7,000, while the number of jobs paying more than $28,000 declined. In 1986, 81 percent of all jobs created were in the service or retail sector.

Contingent Workforce. American business is relying more heavily on the rising "contingent workforce," the temporary, part-time, or home-based workers, who number approximately 20 million people. These people make half the hourly salary of full-time workers, receive fewer benefits, and have less job security than full-time salaried workers. The number of people working part-time

involuntarily has risen 60 percent since 1979.(4, p. 19) Part-time workers represent the majority of the five million Americans paid minimum wages or less. Forty-four percent of these workers are women and 22 percent men. These workers make an average of $4.42 per hour compared with $7.43 for full-time workers. Women, teenagers, and minority workers often are paid less than others in similar jobs, and they frequently work in lower paying food service and retail sales jobs.(9, p. 10)

Young Families. Young families have been hit especially hard by the economic downturn. What growth did occur between 1973 to 1986 benefited all American families in all age groups from all regions, except young families. While median family income went up 4 percent nationally for families with a household head of at least 35 years, median income declined 3 percent for families with a 25- to 35-year-old head of household. The decline was even worse for 15- to 24-year-old household heads who experienced a 24 percent decline--almost entirely occurring since 1979.(5, p. 85)

Shrinking Middle Class. All of these factors contribute to the shrinking of the American middle class. In the 1980s, four times the number of Americans fell out of the middle class as climbed above it. The gap between the rich and the poor is now wider than at any time since the Census Bureau began collecting these data in 1947.

Costs of home ownership, which have symbolized middle class stability, illustrate this decline. The National Association of Homebuilders reports that a family must have earned $37,000 annually to own a home in 1985, while the median family income was $27,000. In 1949 a median income worker spent 14 percent of his gross monthly income on mortgage payments. In 1985 a worker at the same income level spent 44 percent.

Families at the bottom of the income scale are in worse distress. Four million more women and children fell into poverty between 1980 and 1984, largely due to federal and state cuts in support programs. Between 1968 and 1983, the poorest 20 percent of families with children experienced a drop in their share of income from 7.4 to 4.8 percent.

Factors Placing Families at Risk. While a vast majority of families provide a nurturing and supportive environment for their children, reports of abuse and neglect rose 90 percent between 1981 and 1986. In 1986 the number of reports of abused children and adolescents was 2.2 million.(5, p. 200) Child fatalities have increased a dramatic 23 percent in 1986, double the rate of the 1985 increase. These percentages are exacerbated by the fact that social mobility has meant that many abused or neglected children have no extended family from which to receive support, where previously a grandmother or an uncle might have provided nurturance for the child.

While determining the causes of abuse or neglect must be done on a family-by-family basis, there are certain factors that place some families and their children at significant risk of instability and dysfunction. Further, although these factors transcend economic class boundaries, poverty places additional stress on families and contributes to family instability and abuse.

One factor is simply the negative family experiences that the parent in the current family had as a child. Parents who were neglected or abused as infants and children are at risk of similarly neglecting or abusing their children. Incest is transferred across generations, with disastrous results. A person who has not been nurtured as an infant is unlikely to be capable of bonding with his own children when he becomes an adult.

A second risk factor is teenage and out-of-wedlock childbearing. Nationally, an estimated 80 percent of foster placements come from the 20 percent of American families that are headed by a single parent.(3, p. 12) Unwed teenage motherhood has more than tripled from what it was 25 years ago. Although it cannot be proven, some experts believe that young parents under the age of 19 tend to be more abusive than older parents. However, this may be due to increased stress of poverty and lack of education and parenting skills rather than youth. Teenage mothers also are much more likely

to fail to receive prenatal health care during pregnancy, another form of neglect that shows itself in much higher levels of low birthweight babies.

This is not to say that these risk factors inevitably place these families at risk. In fact, research indicates that a number of positive interventions can be successful in reducing the likelihood of abuse or neglect in families with these risk factors. Research also shows that parents in these families do care for and want the best for their children. Absent support and assistance to this end, however, research clearly indicates that far too many of these at-risk families will be unable to fulfill these goals and their parental responsibilities. Research also shows that these failures are likely to show up in subsequent generations of families as well.(3)

The Country's Changing Demography

As America's families struggle with their changing structure and with the nation's faltering economy, they are also facing profound demographic changes. The changing ethnicity and the aging of the nation's citizens will affect both the family's character and its functioning in the years ahead. By the turn of the century, the country's population under age 18 will increase dramatically. Also by the year 2000, more Americans will be 65 years or older, and the number of people 85 years or older will increase by 81 percent.

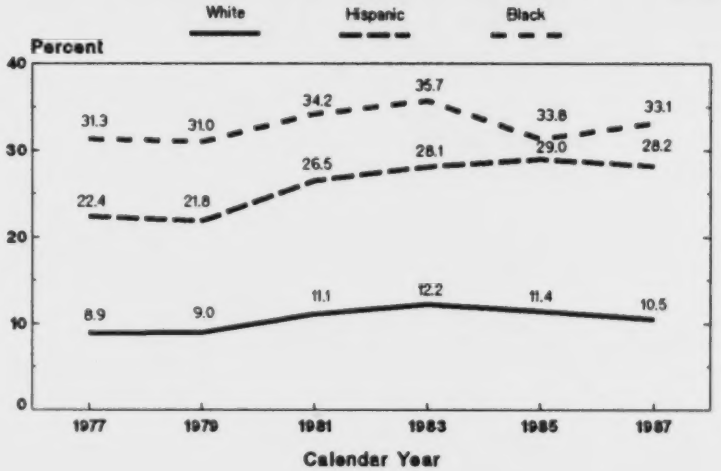
The nation is evolving into a multiracial, multicultural, and multilingual society. According to the U.S. Bureau of the Census, blacks comprised 12.2 percent of the population in 1987, and Hispanics represented 18.8 percent.

Census reports estimate a 16 percent national growth rate from 1980 to 1985 for Hispanics, which contrasts to 3 percent for the total population.(8, p. 4) The Hispanic population is considerably younger than the non-Hispanic population, and Hispanic families continue to have more children. While poverty rates declined among non-Hispanic Americans in the mid-1980s, the poverty rate for Hispanic Americans remained the same in 1987 as during the recession of the early 1980s. Hispanics are the only racial or ethnic group with poverty rates at recession levels.(13, p. v) Poverty has worsened for Hispanic married couples, Hispanic children, and Hispanic elderly. All regions of the country have been affected, and poor Hispanic families are growing poorer. Recent federal budget cuts in social services programs has been linked to this increase in Hispanic poverty.

Although poverty rates for blacks did not increase in 1987 as they did for Hispanics, one out of every three blacks lived in poverty and the poverty rate for black children under 18 was 45.6 percent.(14, p. v) Increases in poverty are especially sharp among young black families, among those without college educations, and among blacks in the Midwest. As with Hispanics, poor black families have fallen deeper into poverty, also in part due to recent federal budget cuts.

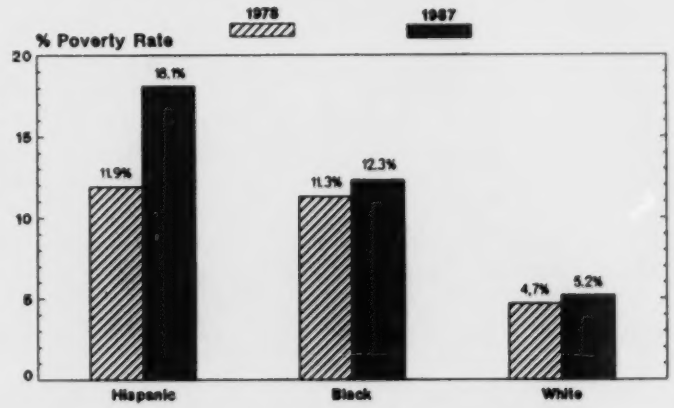
Attention to the needs of minority youth is lagging in public policy development. Not only will the youth of today need better tools to become the responsible parents and self-sufficient workers of tomorrow, but they will be faced with a multiplicity of problems only now being anticipated. Access to language and literacy will be critical in the years ahead. Job opportunities will continue to change, and education and training will become lifelong processes as a necessity for workers to respond to the nation's needs and the distribution of resources. The information needs of the country will also continue to change, and the better paying jobs will require computer literacy and an understanding of information systems.

Figure 1.
Poverty Rates by Race and Ethnic Origin



Source: *Shortchanged: Recent Developments in Hispanic Poverty, Income and Employment.* Washington, D.C.: Center on Budget and Policy Priorities, November 1988.

Figure 2.
Poverty Rates of Married Couple Families by Race and Ethnic Origin



Source: *Shortchanged: Recent Developments in Hispanic Poverty, Income and Employment.* Washington, D.C.: Center on Budget and Policy Priorities, November 1988.

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FAMILY WELFARE POLICY AND WELFARE REFORM

Commentary

State legislatures increasingly are active in adopting legislation to reform their public assistance programs to enable recipients to achieve self-sufficiency. The need to transform the welfare system into a transitional vehicle for able-bodied public aid recipients to achieve self-sufficiency is a major objective of state and federal policy deliberations. State legislators are placing more emphasis on meaningful education and work skills for welfare clients to secure gainful employment.

States have broad discretion over public assistance, which results in widely divergent state policies. Federal standards often reflect variations in assistance programs to specific populations of poor people. State legislatures play a pivotal role in determining the form and extent of government assistance for low-income households, especially with programs having weak federal standards.

Families with children receive primary cash assistance through the AFDC program, which is jointly funded by the federal and state governments. States pay an average of 46 percent of total program costs. AFDC benefit levels are not federally mandated and vary from a low of $120 maximum monthly benefit for a three-person family in Mississippi in 1988 to a high of $779 in Alaska.(2, Table 6)

The link between education, training, and self-sufficiency has been the foundation of most state welfare debates. This connection is supported by the following facts:

- Female-headed, single-parent households comprise most of the 3.7 million families on welfare rolls;
- Twenty percent of the nation's children and half of the country's black children live in poverty;
- Thirty-five million Americans, 33 percent of whom are children, lack public or private health insurance;
- Fourteen percent of the nation's youth fail to graduate from high school, and in urban areas drop-out rates approximate 50 percent; and
- Twelve percent of adolescent girls are mothers, and 1.1 million teenagers become pregnant each year.

These severe conditions present costly public assistance problems for the states, and state legislatures increasingly are involved in all aspects of human services policy deliberation. They have responsibility for appropriating funds for new programs, establishing program guidelines, overseeing program outcomes, funneling federal funds to state human services programs, and balancing constituent demands for human services with other budgetary concerns.

Federal Policy

The Family Support Act of 1988 revises the nation's welfare structure. The cost of the legislation will be $3.3 billion over a five-year period.

The new law replaces the AFDC program--the basis of the welfare system--and the Work Incentive Program (WIN) with education, job training, and work activities. States will be required to develop Job Opportunity and Basic Skills (JOBS) training programs to move welfare recipients into gainful employment. Federal funding for JOBS will be set at $600 million in FY 89, rising to $1.3 billion in FY 95. The bill also mandates that states meet participation rates by enrolling a certain number of recipients per year in JOBS activities. All states will be required to operate the Aid to Families with Dependent Children-Unemployed Parent (AFDC-UP) program beginning in 1991, and AFDC-UP parents will be compelled to engage in part-time employment. It also mandates fraud detection procedures. Additionally, states must guarantee 12 months of child care and medical assistance transition benefits to families who leave the welfare rolls and obtain employment.

The bill specifies the following requirements for the states:

- Automatically withhold court-ordered child support payments for orders being enforced by their child support agencies by November 1, 1990;
- Automatically withhold wages for all child support orders, whether or not parents have sought assistance by January 1, 1994;
- Meet federal standards for the establishment of paternity by October 1, 1991;
- Meet federal regulations regarding required state response times for requests for assistance--regulations must be published by April 13, 1989;
- Develop plans that will describe the implementation of the JOBS program; the plan must be approved by the Department of Health and Human Services and be in operation by October 1, 1990;
- Match funds at the rate of 10 percent for allotments equal to 1987 WIN allocations; for funds exceeding states' WIN allocations, the match will be either 60 percent or states' Medicaid matching rates for nonadministrative costs;
- Make a broad range of job training activities available under the JOBS program by October 1, 1990;
- Make the JOBS program available in every political subdivision of the state by October 1, 1992;
- Meet participation rates by enrolling a certain percentage of AFDC parents in the JOBS program each year (7 percent in FY 90; 7 percent in FY 91; 11 percent in FY 92; 11 percent in FY 93; 15 percent in FY 94; and 20 percent in FY 95);
- Sanction individuals who fail to meet JOBS program requirements or refuse to accept an offer of employment;
- Guarantee child care for individuals who need care to work; the program must begin no later than October 1, 1990;
- Provide transitional child care and medical assistance by April 1, 1990;
- Implement the AFDC-UP program, extending benefits to two-parent families where the major wage-earner is unemployed, if it is not already in place, by October 1, 1990;

- Meet participation rates for the enrollment of AFDC-UP parents in a JOBS work activity in fiscal years 1994 through 1998; and

- Establish measures to detect fraudulent AFDC applications by October 1, 1989.(1)

In addition, the federal legislation authorizes demonstration projects, dependent on appropriations, to test education and training programs for children receiving AFDC; in-home early childhood development programs; effective methods of coordination and services to promote long-term family self-sufficiency through community-based organizations to provide comprehensive family support services; employment of AFDC recipients as child care providers; alternative definitions of employment; innovative custody and visitation provisions of court orders; employment opportunities for low-income individuals; and counseling and services to high-risk teenagers.

State Policy

According to a recent NCSL survey, 32 states introduced 81 pieces of welfare reform legislation in 1987 and 1988. By the end of July 1988, states had passed 16 pieces of welfare reform legislation, and 13 bills were pending. Task forces to study the problem were proposed in almost one-fourth of the states. The survey indicated that:

1) States are emphasizing the link between education and training and welfare benefits;

2) States are aware of the need for comprehensive welfare reform legislation with various programs to address the many causes of welfare dependency; and

3) States are requiring increasingly rigorous evaluations of new welfare reform programs.

In 1987 and 1988, at least 14 states--Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Rhode Island, and Washington--reported passing comprehensive welfare reform legislation. These efforts have incorporated new and existing state and federal programs to address specific state needs, including: extensive employment and job training programs, case management services for clients with problems affecting their ability to work, appropriate professional and personal counseling to ready the client for work, identification of at-risk program participants, employment incentives, supplemental and transitional services, and employer incentives.

The following state examples are of recently enacted comprehensive welfare reform programs:

- The Kansas "Kanwork" program, adopted in 1988, provides for mandatory education and training; child care, health care, and transportation supplemental services; remedial education and counseling services; case management workers to help participants negotiate the system; community work programs; grant diversion; client-agency agreements with sanctions; six months transitional child care on a sliding fee basis; 12 months' transitional health care; six months' transitional transportation subsidies; and a special allowance for uniforms and tools for approximately 10,000 participants. All AFDC recipients with children three years or older must participate, and long-term recipients are targeted for special assistance. The state has committed approximately $6.4 million in state funds to an approved $11.7 million budget.

- The Maine welfare program is called the Additional Support for People in Retraining and Education (ASPIRE). The program is required for welfare recipients with children three years of age and older. Teenage parents are also required to participate in a program especially designed to encourage the completion of education and the enhancement of self-sufficiency. Special assistance is given to first-time pregnant women

during the third trimester of pregnancy. Coordination of human services and Job Training Partnership Act (JTPA) activities is mandated to provide job training and education services. These services include support services and up to 12 months of transitional services, such as respite care and medical assistance, in accordance with the participant's employability plan. However, families with gross monthly income equaling more than 150 percent of the federal poverty income guidelines shall be ineligible for extended medical assistance. A separate report on teenagers and adults must be submitted to the legislature by February 14, 1990, evaluating the program and its participants' achievements as outlined in statute.

- Minnesota appropriated $58.6 million in state funds for the Partnerships to Aid the Homeless (PATHS) Program in FY 89. Although it includes mandatory provisions, PATHS is largely a volunteer program to provide employment training, education, and support services, such as child care and transportation, to all recipients. However, legislation was pending at the conclusion of the survey to require all minor parents to attend high school once their child is six weeks old. Case management is utilized to expedite the program objectives, and the administering counties are required to focus outreach and recruitment on the priority groups: long-term recipients, caretakers under the age of 21, and caretakers without a high school diploma or General Education Degree (GED). The program also includes remedial education, English as a second language, grant diversion, and job search. Local plans include involvement of employment and training agencies, social services, basic education providers, post-secondary schools, and other community organizations involved in helping low-income populations. PATHS targets a population with multiple barriers and needs through this interdisciplinary approach.

- The New Jersey Realizing Economic Achievement Program (REACH), enacted in October 1987, will serve 93 percent of the state's AFDC population by 1989. All able-bodied recipients are required to develop a plan for achieving self-sufficiency, and heads of households, in which the youngest child is at least two years old, must participate in education, job training, or employment activities. Counties are responsible for planning and administering the REACH program. REACH participants have a case manager to explain the program; identify barriers to self-sufficiency; refer to service providers; develop a self-sufficiency plan with recipient; monitor progress; correct possible discontinuities in service delivery; take necessary actions regarding sanctions; evaluate post-AFDC needs; and monitor eligibility of child care, transportation, and medical assistance to qualified post-AFDC recipients.

- Washington enacted the Family Independence Program (FIP) in 1987, and it became effective July 1988. The program is voluntary for the first two years, after which it will be mandatory only if job placement rates are sufficient. The program contains extensive employment and job training, case management services, identification of at-risk participants, personal and professional counseling to ready participants for work, work incentives, and employer incentives. The AFDC income disregard was replaced with a flat incentive payment of 105 percent of the FIP poverty level for people in training programs, 115 percent for those who obtain part-time employment, and 135 percent for those in full-time jobs. Until the passage of the Family Support Act of 1988, the Washington program was one of the few state welfare programs to provide 12 months of child care, transportation, and medical assistance to participants who lost AFDC eligibility by becoming employed. These services have a statutory maximum on a copayment provision.

Twenty-five states evaluate or update their income maintenance benefit levels regularly. Twelve states annually review benefit levels, and Hawaii, Minnesota, Nevada, North Carolina, North

Dakota, Oregon, Texas, Wisconsin, and Wyoming review need and payment standards with the biennial budget cycle. Eight states--Connecticut, Hawaii, Indiana, Kentucky, Nebraska, North Carolina, Tennessee, and Wyoming--introduced legislation to review or increase income maintenance benefit levels in 1987 and 1988. Although evaluation of benefits may be conducted yearly, many states report that increases have not been made due to lack of state funds.

Under the Family Support Act of 1988, all states are required to establish an AFDC-UP program. Twenty-three states provide services to two-parent families through the AFDC-UP program. Florida, Indiana, North Carolina, and Wyoming passed this legislation in 1987 and 1988.

Key Points

In examining the problems associated with state family welfare policy, the following points should be considered when developing public policy:

- Most people on public assistance are women and children.
- The women heading most of the single-parent households on the welfare rolls are uneducated and lack basic skills to find employment that will enable them to support their families.
- Intervening to prevent adolescent pregnancy and to provide services to parenting adolescents to encourage them to complete their high school educations will significantly reduce the welfare rolls.
- Welfare recipients' efforts to complete self-sufficiency programs are often thwarted by complicated bureaucratic requirements of numerous state agencies.
- In order to work, or gain the skills leading to employment, people need support, such as child care, medical assistance, and transportation.
- Once a recipient becomes employed, she often receives too little to support her family in addition to losing the support benefits associated with public assistance grants.
- Economically distressed communities may have a difficult time placing public assistance recipients, even if they are properly trained.
- Coordination of state human service, job training, and education agencies is critical to the success of welfare reform and the development of self-sufficiency programs.
- A strong evaluation component in welfare reform programs assists in developing accountability and the long-term success of self-sufficiency efforts.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to implement parent education programs:

- Require an assessment of income maintenance and job training programs in the state.
- Review state program services in relation to the federal mandates, regulations, and deadlines of the 1988 Family Support Act.

- o Develop coordination mechanisms on welfare programs among state human service, education, and job training agencies.
- o Improve the enforcement of child support orders and the establishment of paternity under the new provisions of the 1988 Family Support Act.
- o Target adolescent parents and long-term welfare recipients for program services.
- o Analyze job availability and create policy that requires coordination between jobs and job training.
- o Develop a coordinated system of public assistance client services to expedite public assistance services, make program requirements easier to understand, and provide for follow-up client evaluations.
- o Ensure necessary support and transition services in self-sufficiency programs, such as child care, transportation, medical assistance, and housing.
- o Evaluate income maintenance eligibility and benefit levels annually to ensure that poor families in need receive sufficient assistance to satisfy the basic needs.
- o Develop scientific evaluation methods for all programs that propose to contribute to the self-sufficiency of public assistance recipients.
- o Coordinate state administration of JTPA and human services. Evaluate the impact of education and job training programs on families and child development to ensure the integration of all welfare efforts for greater benefit to children.
- o Consider adding family support services, including parent education and family enrichment programs, and post-employment services to state services for welfare recipients.

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CHILD ABUSE AND NEGLECT

Commentary

The maltreatment of children is a family problem. While more attention is focused on physical abuse, neglect of children by their families is a greater problem. In 1985, neglect--defined as deprivation of necessities--accounted for 55 percent of child maltreatment reports, while physical injuries were involved in 22 percent of the cases.(1) Sexual and emotional maltreatment were responsible for the balance of reports. In 1985 an estimated 1.15 million families were reported for child abuse and neglect.(1) This total reflects duplicate reports from families with more than one child who may have been abused. However, when allowance is made for duplications, it is clear that child abuse and neglect continues to be a major and increasing problem for families and for society.

From 1976 to 1986, reports of abused children increased from 669,000 to 2.2 million.(1) In recent years, national reports of child fatalities have also soared, rising 23 percent from 1985 to 1986,(3) double the rate of increase the previous year. And from one-fourth to one-half of the children who die from maltreatment have previously been the subject of reported abuse.

Child abuse and neglect has a significant impact on other programs for families. When a child is taken out of the home because of abuse or neglect, he or she is placed in foster care--a costly program for both state and federal government. Society and the individual continue to pay in another way--since many adult offenders were abused or neglected as children.

Over the last two decades, states have responded to the problem of child maltreatment by creating child protective service (CPS) systems that provide mandatory reports, central registries, investigation, prosecution, and protection of child victims and witnesses; assure legal representation for abused children; require background checks for service providers and employees; and provide family treatment services. Despite the best intentions of legislators, law enforcement officials, child protection professionals, and others, the system has not performed adequately.

As the numbers of child abuse and neglect reports have soared, the CPS system has become overwhelmed. In trying to deal with the sheer volume of reports, agencies have had difficulty responding. Workload standards are based on the average time required to complete intake, investigative, and follow-up services in response to abuse or neglect reports. In every state, however, actual workloads are significantly above the standards. The ideal standards for investigations vary from 12 reports monthly for each CPS worker in Illinois to 15 per month in Idaho. Standards for follow-up cases range from 18 per worker in Massachusetts to 30 in Pennsylvania. But in Illinois, for example, the actual workload for abuse and neglect investigations is 50 percent above the standards, and in most states the actual workload for follow-up cases ranges from 10 to 50 percent above the standards.

Given the cost to society and the often irreparable damage to individual lives, the prevention of child abuse and neglect is an essential element of public policy. According to a growing number of observers, there is compelling need to take a holistic approach, recognizing that the family itself is a rich resource offering the best hope of prevention. Treating the abused child alone, as an isolated piece of the puzzle, often does not work and is not cost-effective, since most abused children are returned to their homes. When it is possible to do so without endangering the child, it is considered better practice to leave the family unit intact and provide the services necessary to bring about change within the family.

Policymakers are increasingly interested in examining the entire state system for serving troubled children and families and developing a more comprehensive approach to the multifaceted problems they face. This direction may require a reassessment of the role CPS agencies play in the larger state service delivery system. If so, it may be necessary to redefine the roles of and interrelationships among all agencies serving troubled children and families.

Federal Policy

The federal government officially recognized child abuse and neglect as a national problem in 1963 when the U.S. Children's Bureau developed model reporting legislation, providing the impetus for state action. Congressional enactment of the Child Abuse Prevention Act (P.L. 93-247) in 1974, the first federal program specifically designed to address the problem of child abuse, provided the motivation for additional action by the states.

The Child Abuse Prevention, Adoption and Family Services Act of 1988 (P.L. 100-294) extended through 1991 the authorities established in previous legislation. The 1988 act establishes new discretionary grant priorities for the National Center on Child Abuse and Neglect, including funding of programs and projects for "prevention and treatment of alcohol and drug-related child abuse and neglect." It also provides grants to the states for training and technical assistance involving medical neglect and child sexual abuse investigation and prosecution methods to coordinate professional involvement and reduce trauma to the child.

State Policy

By 1968 all 50 states had enacted mandatory reporting legislation. State policy since that time has been directed toward refinements in statutes and the expansion of agency services in response to the steady increase in reports of abuse and neglect. In fact, the surge in child maltreatment reports has been accompanied by an even greater increase in state legislative activity, particularly in recent years. From 1983 through the 1988 sessions, the number of bills concerning child abuse and neglect enacted by state legislatures quadrupled.(12)

Policymakers have become increasingly concerned, however, with issues related to the functioning of the child protective system. Systems currently in place were developed piece by piece in response to perceived needs at the time, or in response to public demands. In earlier years, they sufficed. As maltreatment reports--and deaths from abuse--have surged, that is no longer true. Child protective systems have been overwhelmed by sheer numbers, sometimes to the extent that it is not possible to fulfill their basic mission of protecting maltreated children. Despite statutory requirements that all reports be investigated, many states have problems meeting that mandate. Arizona, for example, is unable to investigate 15 percent of the abuse and neglect reports that the CPS agency has determined should be pursued. In Florida, 50 percent of the children and families in need of services do not receive them.(4)

Unfortunately, while abuse and neglect reports were increasing at a phenomenal rate from 1976 through 1986, funding of CPS agencies did not keep pace. Federal social service funds channeled to the states through various programs were reduced at a time when states were forced to restrict their budgets. These fiscal restrictions have forced the states to look at more cost-effective programs for addressing the problem of child abuse and neglect, with an emerging focus on family-based treatment and prevention. It is less costly in the long run to concentrate available funding on programs to strengthen families and to prevent future abuse or neglect than to remove children from their homes. Family preservation services are the most concentrated of these programs. They offer an intensive, time-limited approach to teach troubled families new skills and enable them to care safely for their own children.

An emerging trend resulting from this concern of policymakers for cost-effectiveness is a focus on interagency coordination and service delivery. In 1986 and 1987 alone, at least 21 states enacted legislation aimed at improving systems coordination.(9 and 10) Mechanisms ranged from flexible funding strategies and interagency case management to family policy development and coordinating councils. States enacting legislation in this area include California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Maine, Minnesota, Missouri, Nebraska, New Hampshire, North Dakota, Ohio, Rhode Island, South Carolina, Tennessee, Texas, and Washington.

The trauma that abused children can experience during legal proceedings led to legislation designed to protect child victims and witnesses. Some states no longer require certain children who may be further traumatized to face the defendant in open court. The U.S. Supreme Court has ruled, however, that some procedures currently allowed by the states deprive a defendant of the constitutional right to face an accuser. The implication is that states may be vulnerable to future litigation if they permit the use of courtroom barriers and other techniques without a specific court determination that they are necessary to protect the child.

Key Points

In examining the problems of state child abuse and neglect policy and CPS systems, the following points need careful consideration:

- More than two million reports of child abuse and neglect are made annually to designated state agencies.
- While the annual rate of increase in reports has declined slightly in recent years, they are still increasing at a rate of 10 to 12 percent a year. Deaths resulting from child maltreatment are a major concern, rising 23 percent in a single year.
- CPS systems have become overwhelmed by the volume of reports, so that systems often are unable to perform adequately.
- Child maltreatment has a significant impact on the entire range of state social service programs. It is the driving force behind costly programs such as foster care.
- The best hope for preventing child abuse and neglect lies in strengthening the family and enabling the family unit to fulfill its responsibilities appropriately.
- Unsubstantiated reports add to an already overburdened system. An estimated 40 to 45 percent of reports are in this category, but CPS agencies must assess all reports that are made.
- Severe funding problems, accompanied by an increasing number of reports, have made it difficult for child protective agencies to fulfill their mission. Workloads are significantly above standards.
- It may be desirable to reassess the role of CPS agencies and to improve coordination of the services provided by state agencies to children and families.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action for sound child welfare public policy:

- Establish an integrated child and family services system that emphasizes keeping families together rather than removing children; assures safety and permanency for children; and recognizes that the CPS agency is a part of the larger system.

- Determine the adequacy of funding for the CPS agency, including training, staffing level, and service delivery.

- Establish programs designed to prevent abuse and neglect.

- Develop minimum standards for CPS agency staffing and require annual evaluations of reporting information, staff workloads, and funding.

- Review current statutes that provide protection for child victims and witnesses in court proceedings to assure that they will meet tests of constitutionality.

- In states where they do not already exist, establish a centralized computer information system to include--at a minimum--identifying data for each child who is the subject of a report, the type of maltreatment reported, the outcome of the investigation, and assessment of expenditures. Georgia, Kentucky, Maine, Minnesota, New Mexico, North Dakota, and West Virginia have not established central registries. In those states, reports are made to appropriate local or state agencies.

- Review reporting statutes with a goal of assuring more accurate reporting to the CPS agency. Review agency guidelines concerning information to be reported and content of reports. Establish a reporting data system based on the model being developed by the National Center on Child Abuse and Neglect to achieve reliable national statistics.

- Review current laws and policies concerning feedback to professionals who report maltreatment and provide statutory guidelines for providing such feedback.

- Authorize a public information program concerning the child protective services/child welfare system.

- Provide a clear statutory definition of the CPS agency's intake and screening authority, including a definition of reports that the agency will not investigate.

- Establish two major report categories: substantiated and unsubstantiated. Enact statutory safeguards to protect persons who are the subject of unsubstantiated reports.

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ALTERNATIVES TO OUT-OF-HOME PLACEMENT

Commentary

Historically, when a child was abused, neglected, or in need of supervision, the state acted to assume guardianship. Most often, the child was removed from the home and placed in foster care. As a result of this policy, one-half to three-quarters of a million children were estimated by the Children's Defense Fund to be in foster care in 1978.(5, p. 18) After several years of decline in the foster care population, the number of American children served out of the home by state systems is again growing. It is estimated that in 1985 about 455,000 children were in placement with that number increasing to as many as 600,000 in 1989.(12, p. 15)

Although out-of-home placement may be unavoidable in some circumstances, unnecessary foster care contributes to family instability and damages the child. Theoretically intended as a temporary crisis intervention strategy, in reality children often remain in placement for long periods of time. In 1984, 40 percent of the foster care population was in placement for two years or more, with 18 percent placed for five years or more.(10, p. 108)

Removal from their families and prolonged foster care deprive children of the stability and sense of belonging that is essential for their emotional well-being. "Foster care drift," in which children spend years moving among a series of foster care settings, is especially traumatic. Development is further hindered when children are placed in institutional settings that are too restrictive for their needs. When out-of-home placement is unavoidable, steps must be taken to ensure that foster care is truly temporary and that services necessary for the child's well-being are available. The permanency planning movement seeks to assure that each child has a home, either with the natural family or, when reunification is not possible, with an adoptive one.

A large percentage of children are in foster care due to parental neglect, which is often a product of poverty. These parents lack skills to manage a household adequately, nurture their children, and make the money necessary to house and care for their families. Even when children are removed from home, most eventually return to their parents and to the same problems that led to their placement. Foster care does not address the family's underlying problems. By failing to teach the family new behaviors, this approach perpetuates their cycle of failure.

The financial costs of out-of-home placement strain state budgets. Nationally, the average cost for foster care in 1985 was $3,071 per year.(7, p. 1) In many states, a shortage of foster family homes has forced placements in more restrictive and more expensive settings. In Washington state, for example, costs range from almost $21,000 per year for placement in a group home to $103,000 for long-term psychiatric care.(1) The number of children committed to psychiatric facilities, often the most expensive service option, is increasing at an alarming rate in a number of states. The nationwide trend of rising placement costs is expected to continue.

At the same time, financing systems in most states actually provide incentives for out-of-home placement. Traditional reimbursement systems, methods for contracting services, numerous program-specific line-item appropriations, and what amounts to an open-ended entitlement to foster care funds often encourage placement and create disincentives for alternative services. Common financing systems lack the flexibility for caseworkers to help a family obtain the variety of services that may be needed to prevent placement.

Service providers report that children in the child welfare system and their families have increasingly complex problems and needs. Often, they need services from a variety of uncoordinated, bureaucratic systems with many falling through the eligibility cracks. Families face a maze of eligibility criteria, caseworkers, and gaps in the array of services available. In addition, research shows marked similarities in families and children involved in the child welfare, juvenile justice, and mental health systems. Often, they respond to and need the same types of services, but their access may be restricted due simply to the limitations of the system that they happened to enter.

Increasingly, policymakers are recognizing the potential for troubled families to learn new skills necessary to care for their own children. Recognition of the importance of family to a child's healthy development, advancement of new in-home treatment technologies, and the financial pressure of increasing placement costs have contributed to state lawmakers' interest in creating family-based child welfare public policy.

Federal Policy

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) redirects federal fiscal incentives to encourage alternatives to out-of-home placement and requires certain protections for children. At the heart of P.L. 96-272 is the requirement that states make "reasonable efforts" to keep families together through the provision of family-based services.

The federal government provided the impetus for broad reform but has given the states little guidance in effective implementation. The U.S. Department of Health and Human Services has been slow to issue regulations interpreting the law, and the regulations that it has issued have been vague. The fiscal incentives of the act have lost some of their effectiveness as a result of federal budget cuts and delays.

State Policy

The goal of family-based child welfare is to provide for the best interests of the child by teaching families new skills and providing needed support services. By helping families remain intact, states establish a continuum of care in which out-of-home placement is no longer the prevalent approach. With these services in place, it is necessary to remove a child from home only in an emergency or an extreme situation; often the family can be reunited soon.

In addition, legislators are concerned with improving the foster care system, so that placements, when necessary, contribute to the child's well-being. Training for foster parents is required in an increasing number of states. Efforts to ensure that foster care placements do not become long term include: periodic case reviews, procedures to terminate parental rights after all attempts at family reconciliation have failed, and incentives for finding adoptive homes for children. Alternative, permanent arrangements, such as independent living arrangements for older youth, are also increasingly considered as options.

The preference, however, is to avoid placements when possible by teaching families new skills and resources. Intensive, short-term, family-based services offer a promising alternative to foster care. A number of states and localities are experimenting with this method of preserving families. Family preservation services, the most concentrated model of family-based programs, target families with a child at imminent risk of placement. Founded on evidence that crises offer real opportunities for changing destructive behavior patterns, this service approach differs from the traditional approach in a number of ways. Specifically, family preservation is oriented to the functioning of the entire family unit, not just to treatment of an individual member in isolation. Family preservation services provide limited caseloads of two to five families, 24-hour caseworker availability, intensive contact with the family, treatment usually limited to from four to six weeks, and a diversity of services based on individual family needs. Most programs have the flexibility to arrange for "hard" services--housing,

food, transportation, and emergency financial assistance--as well as more traditional "soft" services--counseling, child care, homemakers, or parenting education.

States are using a variety of approaches to implement family preservation services. A number have initiated statewide programs, and still more have started pilot projects to test the services on a local basis, monitoring their effectiveness before broader implementation.

In 1987 Iowa legislators created a three-year pilot project with specific conditions for providing family preservation services. The appropriations language:

1) Specifies the intensity of care;
2) Targets families with children at imminent risk of placement;
3) Limits program duration and requires 24-hour availability of services;
4) Calls for services provided by private, as well as public, agency personnel;
5) Funds active project monitoring and performance evaluation;
6) Requires performance-based contracting; and
7) Allows caseworker flexibility to obtain additional services to keep a family together.(3, pp. 3-5)

The pilot provides an opportunity to test the programmatic elements of family preservation services and the financial framework for delivering them.

Maryland's statewide Intensive Family Services (IFS) program began in 1984 as a pilot program in nine local areas. Evaluation of the early pilots revealed success in preventing unnecessary out-of-home placement of children. The results also documented that foster care placement rates declined in those areas with IFS programs. These data and the reduced costs associated with prevented placements provided the basis for gradually expanding the services throughout the state in 1988.(9, p. 1)

A majority of family preservation programs nationwide are provided through contracts with private providers, principally because availability of state employees on a 24-hour basis would be problematic in many states. In some states, such as Maryland, however, services are provided by state employees working in two-person teams consisting of a social worker and a paraprofessional parent aide. The program features a flexible fund that budgets $600 per family to purchase services or provide emergency cash assistance necessary to prevent placement.(9, p. 4)

No state at present has mandated an entitlement to family preservation services, but Illinois' recently enacted program was conceived as a statewide entitlement. The governor vetoed the 1987 authorizing legislation (1987 Ill. Laws, P.A. 85-985) with the effect of requiring the Department of Children and Family Services to make services available statewide within a five-year period and to inform families of its responsibility to provide the preventive services.

Homebuilders is one of the oldest family preservation programs nationwide, with more than a decade of experience. Based in Washington, it has served as a model for many projects nationwide. The Homebuilders program is provided by a private agency that contracts with the state on a performance-related basis. Homebuilders' staff must achieve success, which is defined as avoidance of out-of-home placement, in a certain percentage of cases to receive reimbursement for services.

Recognizing the importance of "hard" resources such as housing, transportation, and emergency cash assistance in preventing many placements, lawmakers have helped ensure that such services are available in family preservation programs and have provided other legislative authority for concrete forms of support. For example, a number of states have recently addressed the problems of homeless families and the vulnerability of their children to foster care. Enacted legislation in New York (1988 N.Y. Laws, Chap. 542, Sec. 1) requires the state agency to provide cash grants in the form

of rent subsidies or arrears to families whose lack of housing is the only impediment to returning their children from foster care.

The potential financial savings that family preservation services offer compared with the cost of out-of-home placement make a convincing argument for the implementation of such a program. In 1986-87 the average cost for Homebuilders' family services was $2,600, compared with the expense of an average foster family home placement at $7,186 and an average stay in group care at $23,373. At the same time, Homebuilders reports that 94 percent of the families served remain intact three months later and 75 percent are still together after one year.(1) Not only do the programs protect children while keeping families together, they also can be cost-effective when their costs are compared with those of placing these same children out of the home. The implication for the larger child welfare system is the reduction of increasing placement rates, which promise to break the budget if continued at the current level.

Homebuilders, as well as other family preservation programs, intervenes to prevent placements of children referred from the mental health, juvenile justice, and child welfare systems. Even families with developmentally disabled children at imminent risk of removal have successfully learned new skills necessary to care for their children at home. Tennessee legislation (1986 Tenn. Pub. Acts, S.J.R. 78) directs state departments to develop interagency family preservation pilot projects in locations throughout the state to encourage cooperation in controlling unnecessary placements for all children, regardless of which system they may have entered. The principle of empowerment to solve their own problems applies to many families in crisis, regardless of the system or diagnosis.

Key Points

In examining the problems of state child welfare policy and systems, the following points need careful consideration:

- As many as 600,000 children are currently in out-of-home placement.(12, p. 15)
- The rise in foster care caseloads and costs contributes to a service and financial crisis in many state child welfare systems.
- The proliferation of numerous, categorical funding streams and programs has led in many cases to a service system that is confusing and inaccessible to families in crisis. These uncoordinated systems often result in gaps and duplication in service eligibility, ineffective or nonexistent case management, and lack of effective alternative services.
- States report difficulty coordinating the complex bureaucracies to serve children and families effectively, resulting in what has recently been labeled state child abuse.
- Caseworkers report that in all the state systems children and their families have increasingly complex problems requiring an array of services.
- A majority of children in foster care are placed due to neglect--lack of proper parental care often due to the effects of poverty. An increasing number of children are separated from their families due to a lack of adequate housing.
- Family preservation services are the most concentrated form of in-home treatment with essential characteristics that include time-limited services, small caseloads, intensive caseworker contact, and flexibility to provide a variety of assistance in response to a

family's needs. Such services are provided to families with children at imminent risk of placement.

- In 1988 family preservation services were used to teach an estimated 5,000 families the skills they needed to safely care for their own children.(13, p. 21) Family preservation services protect children while empowering families to solve their own problems through learning new skills and having access to services.

- Although many families in crisis need intensive counseling and support services, a large number of placements can be prevented through emergency aid in the form of rental assistance, transportation, and food. Most family preservation programs have the flexibility to provide an array of these "hard" services as well as more traditional interventions.

- Family preservation programs that properly target families and adhere to the service design are effective in preventing placement of children in the majority of families treated. The broader systemic implication is stabilization of out-of-home placement rates.

- Compared with out-of-home placement, family preservation services cost less on a per case basis. The services can be self-supporting in a relatively short time, with possibilities for long-range reductions in child welfare costs.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action for sound child welfare public policy:

- Direct state agencies serving troubled children and families to develop uniform information systems with the capacity to identify family problems leading to a child's removal from home, the number of children in placement, and the result of services.

- Identify the state expenditures to support children in out-of-home care. Analyze trends and implications for future rates and costs of placement.

- Examine current financing systems for children and family services in terms of fiscal incentives and disincentives for out-of-home placement. Examine reimbursement practices to determine whether they encourage "keeping beds full." Study contracting methods to determine if they encourage desired outcomes. Compare the budget process and funding mechanisms for services that prevent placement with those financing foster care and institutionalization.

- Plan implementation of family preservation services, possibly testing their effectiveness on a pilot basis. Pilot projects can also test mechanisms that encourage interagency cooperation and provide fiscal incentives for alternatives to placement.

- Ensure that programs retain the essential characteristics that make family preservation services effective, including intensity and duration of services.

- Target families with children at imminent risk of placement.

- Incorporate evaluation in family preservation program design. Exercise the legislative oversight role to monitor program effectiveness and analyze cost benefits.

- o **Develop options to facilitate permanency planning for children for whom out-of-home placement is unavoidable and family reunification is not feasible. Review statutes related to termination of parental rights and adoption to ensure that a permanent alternative is provided in a timely manner that is least traumatic to the child. Develop other options that may be appropriate in certain cases, such as independent living arrangements for older youth.**

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Commentary

Protection of the best interests of children in divorce negotiations continues to challenge state lawmakers, judges, and attorneys. Divorce affects more than two million of our nation's children each year. In each case, a delicate balance must be reached in the division of property and in decisions involving custody, visitation, and child support awards.

The three most common categories of custody arrangements resulting from divorce are sole custody, joint legal custody, and joint physical custody. *Sole custody* is the most traditional arrangement, representing over 90 percent of custody awards. In sole custody awards, the custodial parent maintains complete legal responsibility for the child. The noncustodial parent, by informal agreement, may have authority over certain decisions concerning the child and is usually awarded visitation rights.

Joint custody can involve a sharing of legal or physical responsibilities for the child. *Joint legal custody*, the most common joint custody arrangement, allows both parents to share in important decisions affecting the child, such as decisions on education or medical needs. Day-to-day care of the child, however, resembles sole custody with one parent, usually the mother, acting as primary caretaker. *Joint physical custody* involves sharing of caretaking responsibility for the child. In joint physical custody situations, the child maintains a shared living schedule with each parent.

Research on the effects of divorce on children has shown that a continuing relationship of children with both parents is strongly related to healthy psychological development in later years. Because of this research, the "tender years" presumption favoring mothers in custody awards, especially when young children are involved, has begun to lose favor in state legislatures. In the late 1970s and 1980s, lawmakers began to develop "best interest of the child" custody standards that encouraged both parents to be involved with a child's upbringing. Joint custody laws were seen as a step forward in reducing hostility between parents. Several state legislatures went as far as enacting a *preference* for court-imposed joint custody into statute, allowing the courts to order joint custody over the complaints of a parent.

The movement away from maternal preference in custody legislation has had positive as well as negative effects. Although the number of fathers requesting custody is small, a Los Angeles study found that close to two-thirds of the fathers who requested custody were awarded it and a majority of these fathers have been successful parents.(5, p. 233)

From the perspective of mothers, however, loss of the maternal custody preference has compelled many women to compromise their financial interests in uncontested cases, as noted by attorney Nancy Polikoff:

> The fact that women no longer feel assured of getting custody has had its major impact outside the courtroom. It's significantly changed the bargaining climate in uncontested cases. Women who are scared to death of losing custody will trade away anything else--child support, property, alimony--to keep it from happening. They'll end up bargaining away a substantial amount of their potential financial recovery.(5, p. 243)

The increased popularity of joint custody legislation has had mixed effects. Despite the presence of joint custody laws in two-thirds of the states, sole custody awards to mothers still predominate. When parents maintain a cooperative relationship, however, joint custody often contributes to the well-being of the child. Yet in many situations, joint custody is ordered above the objections of one of the parents. Many professionals have argued that such legal preferences for joint custody force antagonistic parents to cooperate--a prescription that prolongs the tensions of divorce for children.

Visitation awards in sole custody situations also can affect adversely the economic and psychological well-being of children. Concerned fathers and fathers' rights organizations are often frustrated by the lack of mechanisms available to enforce visitation orders. As a result, lack of access to visitation is often cited as a reason for nonpayment of child support. Children in these situations are hurt doubly, since they are denied time with their fathers as well as denied the child support they deserve. And fathers who are uninterested in spending time with their children also can use denial of visitation as an excuse to avoid payment of child support.

Mediation programs have gained popularity as a method to decrease the acrimony associated with divorce. The goal of mediation is to promote and serve the best interest of the child by involving both parents in a dispute resolution process that can result in a voluntary settlement. Mediators provide an outlet for parents to move beyond personal conflicts, promote cooperation, and focus on the needs of the child.

The task for lawmakers at both the federal and state levels is to identify the programs and procedures that most often serve the best interests of children and that most fairly meet the needs of divorcing parents.

Federal Policy

The most significant federal legislation passed to date is the Parental Kidnapping Prevention Act of 1980. The act, in combination with the Uniform Child Custody Jurisdiction Act (UCCJA), requires state courts to give foreign custody orders full faith and credit. The act also requires the federal Parent Locator Service to be made available when either parent kidnaps a child.

Recent federal child support legislation has begun to address the relationship between child support, custody, and visitation. Case law in the states provides that visitation and child support are separate, and denial of visitation by the custodial parent does not relieve the absent parent of his or her child support obligation. Still, absent parents persist in using denial of visitation as an excuse to withhold child support payments.

Section 23(b)(1) of the Child Support Enforcement Amendments of 1984 offered a "Sense of the Congress" that state and local governments should focus on the problems of child custody and visitation as factors contributing to the nonpayment of child support:

It is the sense of Congress that

> state and local governments must focus on the vital issues of child support, child custody, visitation rights, and other related domestic issues that are properly within the jurisdictions of such governments.

The 1988 Family Support Act increased federal involvement with custody and visitation issues by authorizing $4 million for demonstration projects to address child access (visitation) problems. Section 505(b) states that demonstration projects funded by the federal government should involve "development of systematic procedures for enforcing access provisions of court orders, the establishment of special staffs to deal with and mediate disputes involving access (both before and

after a court order has been issued), and the dissemination of information to parents." As of this writing, however, funds for the child access demonstration projects have not been appropriated.

State Policy

State custody and visitation laws have undergone significant changes as traditional family structures have changed and as ideas on the importance of both parents in child rearing have gained currency. Despite these legal changes, however, most custody awards in uncontested cases continue to go to mothers.

All 50 states have adopted the UCCJA to assist in communications between states in contested custody cases. States have also updated their standards for custody awards and modifications, provided for appointments of guardians ad litem to represent children in divorce cases, expanded joint custody laws, clarified enforcement remedies for custody or visitation interference, and increased use of mediation to resolve divorce disputes.

Standards for Custody Awards and Modifications. Many states have specific statutory standards or guidelines for custody awards, often based on the Uniform Marriage and Dissolution of Marriage Act. Michigan, for example, has specific definitions for the "best interest of the child" standard. The standard addresses several factors, including the capacity of the parties to love the child, the mental and physical health of the parties, the need for continuity in the child's residence, the child's custodial preference (when the maturity of the child is taken into account), and the ability of each of the parents to encourage an ongoing relationship between the child and the other parent.

Some states have passed legislation that specifically addresses domestic violence issues in custody determination. A Minnesota law allows the court to consider the effect of domestic abuse on the child, while a Utah law provides for investigations into child abuse allegations made during divorce proceedings and delays final custody or visitation determinations until the investigation is completed.

Standards for modifications or changes in custody have also been updated by the states. In most states, a material change of circumstances is required for a custody modification to take place. Minnesota law provides for change of custody only if there is a risk of endangerment to the child in the existing custodial situation.

Appointment of Guardians ad Litem. Some states provide for appointment of guardians ad litem to represent the child in contested custody cases and in cases where a parent is suspected of abusive behavior. The guardian represents the interest of the child and performs an investigation into the fitness of the parties, conducts interviews with children, and reports findings to the court. In New Mexico and Wisconsin, guardians are appointed in all disputed custody cases.

Joint Custody Laws. The rationale for joint custody orders, often stated in statute, is that public policy should ensure frequent and meaningful access to both parents and encourage both parents to retain responsibility for their children.

About 30 states have enacted joint custody laws, although existing laws vary greatly and fall into four basic categories. Most states with joint custody laws allow joint custody *as an option* if it is in the best interest of the child. A second type of joint custody statute is one that allows the court to award joint custody *only if both parents agree to it*. A third type of statute allows joint custody to be ordered at *one party's request*, and the fourth statutory type gives *a preference or presumption* for joint custody.

Some states, such as Colorado, have enacted child support guidelines that take joint physical custody arrangements into consideration. This enables child support determinations to incorporate a

fair estimate of the increased costs associated with providing two homes for the child. On the other hand, Wisconsin law specifies that joint custody should not affect the amount of child support ordered.

California's joint custody law, passed originally in 1980, was the first in the nation to permit joint custody awards over one parent's objection. Since then, several states have passed laws that give preference to joint custody arrangements over sole custody.

In 1987 California's Senate Task Force on Family Equity concluded that the state's joint custody law was being widely misinterpreted as a law creating a joint custody presumption in the courts. The task force was concerned that this preference for joint custody was being used to lower child support obligations. Recent legislation clarified that the state's joint custody law does not give preference to joint custody and treats joint and sole custody as equal options.

A Massachusetts Bar Association subcommittee arrived at a similar conclusion regarding the state's apparent presumption for joint custody:

> While the enactment of the (joint custody) statute was conceptually well intended, its implementation has been inconsistent and fragmented. Despite our Supreme Judicial Court's definite statements . . . that there is no presumption in favor of joint custody of minor children (especially joint physical custody), the confusion and arguments appear to continue. As a result, parents who lack the goodwill, capacity and ability to cooperate are enabled with a joint custody order to further exacerbate and prolong the damage of divorce upon children.(1, pp. 10-11)

Remedies for Custody and Visitation Interference. Most states have enacted laws making it a felony for either parent to abduct his or her child. Contempt of court is the remedy most often employed when a custodial parent refuses to honor court-ordered visitation rights. However, courts are often hesitant to jail a custodial parent due to concern that imprisonment will have a harsh impact on the child.

Colorado's list of remedies for visitation interference includes make-up visitation, posting of bonds of securities, fines or jail sentences, or modification of custody awards.

Mediation Programs. Use of nonadversarial approaches to resolve disputes are gaining popularity in the states. Statutes for court-connected mediation services have been enacted in California, Florida, Maine, Michigan, and Washington. Colorado recently passed a law that allows the court to require parties to seek mediation when a dispute concerning visitation arises. Mediation services can be funded by earmarking divorce filing fees or marriage license fees, or by charging fees for mediation services.

California's mandatory mediation law has been in effect since 1981. The law was intended to provide a nonadversarial process for dispute resolution in all custody and visitation determinations. The law also has the goal of "assuring the child close and continuing contact with both parents." Because of this goal, the California Senate Task Force on Family Equity concluded that the mandatory mediation program puts undue emphasis on the settlement goal, usually a goal of joint custody, rather than an emphasis on the best interest of the child. The task force also recommended that safeguards be built into the mediation system to protect parents and children from agreements that result from undue coercion in the mediation process.

In 1985, Maine enacted a law to establish a court mediation service in the superior and district courts throughout the state. The court must refer all contested divorce cases to mediation where

minor children are involved, except for good cause shown. The state court administrator is authorized to contract with qualified mediators for services. The chief justice of the supreme judicial court appoints a court mediation committee to establish policy and monitor the activities of the mediation service. Committee members include the chief justice of the supreme judicial court, the chief justice of the superior court, the chief justice of the district court, and the state court administrator or their designees. Mediators employed by the Judicial Department are immune from civil liability for negligent acts performed within the scope of their duties [Me. Rev. Stat. Ann. tit. 4 Sec. 18 (1985)].

Washington revised provisions of the state parenting act and established a permanent parenting plan containing guidelines for the resolution of future disputes between the parents, allocation of decision-making authority, and residential provisions and financial support for the child. Specific objectives for the parenting plan are outlined by statute to provide for the child's physical care, emotional stability, the changing needs of the child as he or she grows; minimize the child's exposure to parental conflict; and otherwise protect the best interest of the child. Specific guidelines for visitation also are outlined in statute.

Key Points

The following key points merit consideration when examining the fairness of state custody and visitation laws and procedures:

- Contested custody cases account for about 10 percent of the divorces involving children. These are the cases that legislative changes most directly affect.

- Despite the widespread proliferation of custody legislation, sole maternal custody continues to represent the vast majority of court-ordered custody arrangements.

- Joint custody does not guarantee a continuing parental relationship. A California study of joint physical custody found that one-third of the joint physical custody arrangements were indistinguishable in practice from sole custody-visitation arrangements in the same population.

- Joint custody requires an extraordinary level of cooperation, communication, and goodwill between parents.

- Statutes that allow joint custody to be ordered over one parent's objections, or give a preference for joint custody, must be carefully worded to avoid causing harm to the best interests of children. If parents are unwilling to agree to a custody arrangement, it is unlikely they will be willing to share in decision making for the child.

- Numerous studies have concluded that low levels of contact are causal factors in compliance with child support orders. Cooperativeness and contact are strongly interwoven with responsible child support payments.

- Denial of visitation does not relieve the absent parent of his or her duty to support a child financially. A child is hurt twice when one parent withholds visitation and the other withholds child support.

- Mediation reduces the dependence on costly adversarial court proceedings involving contested custody and visitation cases.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to promote the best interests of children in divorce and to provide for resolution of custody and visitation disputes:

- **Require the courts to give priority to the best interest of the child over specific parental custody and visitation arrangements.**
- **Enact legislation that outlines factors to be considered in determination of the best interest of the child. These factors can include: the ability of the parties to love the child and to provide food and shelter; the length of time that a child has lived in a stable environment; the willingness of each parent to encourage a close and continuous relationship between the child and the other parent; and the reasonable preference of the child, if the court deems the child to be of sufficient age to express a preference.**
- **Ensure that courts consider histories of spouse or child abuse before awarding custody or visitation. Existing responsibilities of guardians ad litem can be expanded to provide investigations into allegations of domestic violence.**
- **Support research on the effectiveness of state laws that give preference to joint custody arrangements compared with laws that permit joint custody only upon agreement of the parties.**
- **Adopt child support guidelines to determine child support awards for joint custody arrangements.**
- Provide for court-connected mediation services.
- Provide a list of remedies for visitation interference, including make-up visitation, posting of bonds or securities, fines, and contempt of court, and provide for mediation services to address visitation conflicts.
- Initiate mediation services on visitation before permanent court orders.
- Require a process to clarify the visitation schedule.
- Explore mediation as an option in issuing divorce decrees.

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CHILD SUPPORT ENFORCEMENT: THE IMPACT OF SINGLE-PARENT FAMILIES

Commentary

Both the number and percentage of children living with one parent have grown substantially in the last quarter century. In 1960 5.8 million children, or 9.2 percent of all children under 18, lived with one parent. By 1985 the number had risen to 14.6 million, or 23.4 percent of all children. Most of these households are headed by women, and half live below the poverty line. Consequently, 75 percent of the American poor are women and children. For many of these children, child support provides critical economic resources.(6, pp. 65-66) Even with the passage of the 1984 Child Support Amendments, which required states to apply certain measures to collect and establish support obligations, program performance in the states has been uneven at best. A growing portion of children, particularly those from single-parent families, does not receive parental financial support. Too often welfare provides the sole financial support for children from single-parent families.

To address these concerns in the context of welfare reform, Congress passed the Family Support Act of 1988, which requires more vigorous state action to improve child support enforcement. The federal law addresses the following:

1) Establishment of paternity and child support orders for children born out of wedlock;
2) Mandatory child support guidelines;
3) Routine modification of orders; and
4) Use of immediate income withholding.

A significant number of all potentially eligible custodial parents do not have child support orders, particularly for children born out of wedlock. The most recent U.S. Census Bureau study of child support showed that only 61 percent of women custodial parents were awarded child support in 1985. The study also shows that women who have been married are far more likely to have been awarded child support than women who have never married.(5)

The limited child support collections for children born out of wedlock contributes to dependency on AFDC. Data show that lack of parental marital ties became the predominant basis for AFDC eligibility in the 1980s, increasing from 28 percent of the caseload in 1969 to 46 percent in 1984.(6)

Another child support issue addressed by federal law concerns the inadequacy of child support orders. The mandatory application of child support guidelines in all cases help ensure that orders cover the actual costs of child-rearing. Orders set under guidelines have been routinely higher than those set without their use.

Use of guidelines to update all orders, even those established prior to the passage of guidelines, improves the economic conditions of children. In most states there is no routine, self-starting process for modifying orders to account for changing circumstances and the needs of the children. There are many barriers in states that, in conjunction with the need to retain attorneys and deal with the court process, pose major deterrents to obtaining modifications.

Effective interstate enforcement poses a major problem that has become more severe as societal mobility increases. Studies show that 12 percent of separated parents nationwide live in

different states one year after divorce or separation. That proportion grows to almost 25 percent three years after and to 40 percent eight years after divorce or separation.(5) Parents are able to avoid paying support simply by moving across state lines because of ineffective interstate enforcement. Furthermore, interstate orders are typically about 40 percent lower than the requested amount and are 4 to 8 percent below a previously existing order.(6)

Federal Policy

Specific child support provisions of the Family Support Act of 1988 include the following:

- *Child Support Guidelines*--Judges and other officials are "required" to use guidelines in setting child support awards. States must review the guidelines every four years. Previously states were required to develop guidelines, but their actual use was optional.

- *Modification of Orders*--States must review and adjust individual awards every three years for AFDC cases and at the request of the parent in non-AFDC cases. Current federal regulations recommend frequent modification of orders.

- *Establishment of Paternity*--States are required to establish more paternities and to order genetic tests in contested cases. The federal matching rate for testing costs will be increased to 90 percent.

- *Requirement for Automated Tracking and Monitoring Systems*--Every state is required to have a statewide automated tracking and monitoring system by 1991.

- *Immediate Automatic Wage Withholding*--States are required to initiate immediate wage withholding for all child support orders that are issued or modified. Previous federal law requires states to pursue wage withholding only for delinquent parents.

- *Interstate Enforcement*--A commission on interstate child support enforcement will be established to make recommendations for improvements in interstate enforcement.

State Policy

The Family Support Act of 1988 implements child support provisions that have been proven successful in the states. States have enacted a variety of legislative mandates to simplify and expedite the child support enforcement process.

Traditionally, paternity establishment cases are pursued only if they pose an immediate potential for significant collections. In the short term, paternity cases are costly and difficult to pursue. However, recognizing the long-term financial benefits to the state and children, several states have improved the process. In Nebraska and Oregon, paternity case processing standards have been established. Iowa has adopted time frames by court rule and agency policy requiring cases to be filed within 30 days subsequent to a parent's location. In addition, once a case has been referred to an attorney for processing, a disposition is required within eight months. Wisconsin law requires paternity actions to be filed within six months of an out-of-wedlock child's birth. Several states, including Washington, have appropriated resources for additional staff to work on paternity establishment.

Scientific blood tests are a valuable tool in determining paternity; however, the courts have been slow in accepting their validity. While many states have laws that allow the admittance of blood test results as evidence, only eight states specify that such results create a presumption of parentage. While most states allow fathers to voluntarily acknowledge paternity, a court order is usually required to establish a legal father-child relationship. In 13 states, the voluntary acknowledgment of paternity

is equivalent to a court order. In Alaska and Maine, for example, the child support agency can file a voluntary acknowledgment of paternity with the vital statistics bureau and use the acknowledgment as a legal basis for establishing child support orders. Other states, such as Missouri, have designed a policy in which an alleged father will admit his parentage if test results show a high probability of parentage.

At least 31 states have statutes that allow for establishment of paternity by administrative or expedited judicial processes in noncontested cases. However, as a matter of practice, states often continue to resolve paternity with a full judicial process, resulting in a broad variance of state performance. These procedures have helped eliminate the need for costly trials and reduce court backlog, but they depend on adequate child support staffing.

To ensure equity of orders, nearly all states have adopted numeric guidelines. However, their use varies by state. A majority of states, including Arizona, Colorado, and Delaware, already have laws that mandate judges to use guidelines. In most cases, the judge must justify deviation with specific findings on the record. This approach helps provide a standard of adequacy, improve the equity of child support orders, and increase the efficiency of the adjudicatory process.

Many legal barriers to modification of support should be eliminated with the implementation of the welfare reform mandate to modify all awards periodically. The state of New Jersey has implemented a pilot project to update child support orders routinely for AFDC clients. In a nine-county pilot project, state-initiated modifications resulted in 26 percent of the families leaving the welfare roles due to increased parental support.

The immediate withholding of child support awards from the obliger's paycheck, without waiting for a delinquency to occur, is perhaps the most powerful new enforcement technique contained in the Family Support Act. Several states, including Arizona, California, Hawaii, Minnesota, Ohio, Texas, and Wisconsin, already provide for immediate income withholding upon issuance of a support order, unless a "good cause exemption" is approved by the court. Success of this technique greatly depends on the support of employers and the courts, training of existing staff, and an adequate automated system to track and monitor payments made by employers.(1)

Key Points

In examining the problems associated with child support enforcement and the impact of single-parent families, the following points should be considered in developing public policy:

- Compelling economic and social reasons exist for concentrating additional resources on paternity determination and the establishment of child support orders for children born out of wedlock. Out-of-wedlock births now account for approximately 20 percent of all births. Families with never-married heads of households have increased more than eightfold from 1970 to 1985.

- Child support enforcement can save state revenues by offsetting welfare costs. Sufficient support can remove children from poverty and reduce AFDC growth rates.

- Estimates, based on the federal tax refund offset programs, suggest that approximately 30 percent of the child support cases involve interstate residency of the parents.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action for sound public policy on child support:

- **Establish expedited paternity establishment techniques.**
- **Provide for the admissibility of genetic testing to establish paternity.**
- **Enforce medical assistance support in dissolution decrees and provide for the assignment of insurance benefits for children to the custodial parent.**
- **Actively pursue the enforcement of interstate orders.**
- **Develop and submit a plan for an automated tracking and monitoring child support system in the prescribed federal time frame.**
- **Adopt procedures to simplify the periodic modification of child support orders.**
- **Assure that the child support agency has adequate resources to implement the welfare reform mandates. Training of staff and judiciary is key to a successful program.(3)**

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HOMELESSNESS AND FAMILIES

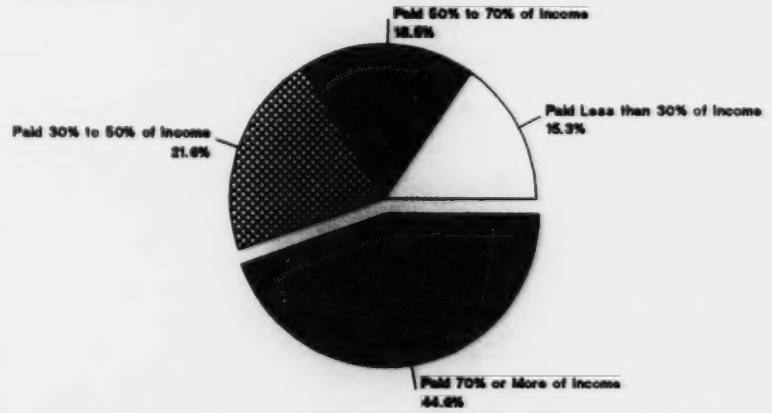
Commentary

Families with children are the fastest growing segment of our nation's homeless population. In 1982 children and their families comprised 18 percent of the homeless. Today, between 28 and 33 percent of the homeless are families, both single-parent and two-parent. Female-headed, single-parent families represent the majority of homeless families. Single women currently account for 25 percent of the homeless population, while in 1982 they accounted for only 10 to 15 percent of those suffering homelessness.(11, p. 3)

Family homelessness results from a complex web of social ills. Families can lose a home due to unemployment or underemployment, lack of affordable housing, inadequate health insurance, or deinstitutionalization. Female-headed families can also become homeless due to domestic violence. Pregnant or parenting teenagers are also at risk of homelessness as a result of running away or being thrown out of their homes.

From a societal perspective, the primary cause of homelessness has been the decline in our nation's stock of affordable and safe housing. In recent years, the supply of low-income housing has fallen dramatically due to federal budget cuts, gentrification, condominium conversion, and building abandonment. Since 1981 the federal budget for housing assistance has been slashed by almost 70 percent.(1, p. 113) At the same time, the number of children in poverty has grown and the income of poor families has dropped. The quality of affordable housing has also declined, leaving many families in substandard units. A study funded by the Ford Foundation found that in 1983 about 9.7 million renters nationwide had incomes below $8,000. Using accepted definitions of affordability, those households could afford to spend no more than $200 a month for housing. In that same year, however, only 5.3 million units in the United States had rents below $200, and 20 percent of those units were in substandard condition.(7, p. 117)

Figure 3.
Percent of Income Spent on Housing by Poor Renters



Source: U.S. Census Bureau American Housing Survey, 1985.
Note: The Census Bureau data do not include most homeless families.

Once a family loses a home, pre-existing problems are exacerbated. Often, children of homeless families lack access to education. In addition, they may be removed from their families and placed in foster care because their parents lack adequate housing. Homeless women are 20 times more likely to be sexually assaulted and three times more likely to become pregnant than women who have a home. Pregnant homeless women, who lack prenatal care or adequate nutrition, often have miscarriages or give birth to infants who die within a year of birth.(11, p. 3)

Solutions to the crisis of family homelessness require short-term as well as long-term approaches. Both emergency temporary assistance and permanent programs to increase the stock of affordable housing are needed. Solutions must also take into account the broad scope of the homelessness problem by integrating housing efforts with social welfare, education, medical and mental health, and job training programs.

In recent years, federal, state, and local efforts have begun to address these issues, but coordination is still a key to successful intervention. As the federal government and localities continue to create alternatives to assist the homeless, state legislatures are in a unique position to oversee use of existing resources and to provide new resources to fill program gaps.

Federal Policy

During the same period that federal budget cuts diminished funds for affordable housing, Congress appropriated more than $400 million through the Federal Emergency Management Agency (FEMA) for emergency food and shelter for the homeless. Changes have been made in federal housing assistance, food stamp, AFDC, Medicaid, mental health, Supplemental Security Income (SSI), job training, and veterans programs to make them more accessible to persons lacking permanent home addresses.

As the lead federal agency in the provision of housing, the Department of Housing and Urban Development (HUD) has taken action through a variety of programs designed to assist homeless individuals and families. HUD-acquired single-family homes have been made available for shelter use. Cities have been encouraged to use Community Development Block Grant (CDBG) funds to address shelter and other needs of the homeless. Public housing agencies have been instructed to give priority status to homeless families on waiting lists for public housing, and regional HUD administrators have made an effort to keep an allocation of Section 8 Moderate Rehabilitation rental assistance certificates available to support local homeless efforts.

The 100th Congress took a major step forward by passing the Stewart B. McKinney Homeless Assistance Act in 1987. The McKinney Act created the Interagency Council on the Homeless to coordinate homeless assistance activities among executive agencies. The act also authorized funds for HUD, and the Department of Health and Human Services (DHHS), Agriculture, and Education departments to increase efforts to provide emergency and transitional housing, outpatient health and mental health care, access to food stamps, and basic literacy education to the homeless. The McKinney Act also stated that homeless children are entitled to a free, appropriate public school education and that residency requirements may not be used to deny access to education.

The McKinney Act, though well intentioned, is seen by many local governments as a complex maze of uncoordinated funding programs under several federal agencies. Heavy responsibilities are placed on localities to ensure that all the resources of the act are used. In addition, many local governments are concerned about future funding of McKinney programs, given the strict requirements of the Gramm-Rudman-Hollings budget limitation act.

The 100th Congress has also passed legislation barring housing discrimination against families with children. The Fair Housing Amendments of 1988 give HUD stronger enforcement remedies in

cases of housing discrimination. The law will ease the homelessness problem by increasing the stock of affordable housing available to families--a supply previously restricted by discriminatory "adults-only" practices.

State Policy

Despite recent increases in federal funding, state and local governments are still the laboratories for innovative solutions to family homelessness. State legislatures are in the position to provide funding, technical assistance, and oversight for new approaches to low- and moderate-income housing, as well as for temporary solutions to the needs of the homeless.

The National Association of Housing and Redevelopment Officials (NAHRO) has identified 21 states that have implemented state homeless programs, in addition to federally funded approaches. Of these states, Massachusetts has developed a coordinated effort among all state departments concerned with homelessness.

The Massachusetts program uses interagency agreements between the Executive Office of Communities and Development and the Departments of Public Welfare, Social Services, and Mental Health. The legislature has created programs to provide transitional housing for homeless families and for pregnant or parenting teenagers. The Housing Innovations Fund was authorized to provide grants for development of alternative housing, such as battered women's shelters, mutual housing, cooperatives, and congregate housing for veterans. The legislature also passed a bill enabling the Department of Public Welfare to purchase rental assistance certificates to provide permanent housing to AFDC recipients who are housed in temporary shelters or hotels.

Other examples of state homeless initiatives include:

- California uses Housing Trust Fund monies for grants for emergency homeless shelters, rehabilitation of hotels and group homes, and emergency AFDC. The legislature is also considering legislation that would establish innovative living units for single-parent families.

- Colorado's Housing Finance Authority has a Special Housing Needs Fund to construct rental housing facilities for groups with special needs, including the homeless. The authority is also developing a transitional housing program that will take advantage of federal Section 8 Moderate Rehabilitation assistance monies.

- Housing Opportunities for Maine (HOME) fund, established in 1982, uses property tax revenues to finance special housing when bonds are not feasible. Maine's Partnerships to Aid the Homeless (PATH) program assists localities in using rental assistance certificates for the homeless. In 1986 the Housing Authority installed a 24-hour emergency housing information service to assist the homeless.

- The Shelter for Homeless Women Program in Maryland provides payments to community groups that assist homeless women, many of whom are victims of domestic violence.

- New Jersey's Prevention of Homelessness Act provides assistance to homeowners and renters in danger of losing shelter.

- New York amended its social services law to enable families with children in foster care to receive rent subsidies when lack of housing is the only impediment to their regaining custody of their children.

- New York's Homeless Housing and Assistance program provides grants and loans to non-profit corporations to rehabilitate dwellings or construct emergency, transitional, and permanent housing for homeless persons.

- The Bridge Housing Program in Pennsylvania, administered by the Department of Public Welfare, provides housing assistance for the homeless during job training and counseling. The goal is to return the homeless to a lifestyle as independent as possible.

Key Points

The following key points merit consideration when examining the causes and effects of family homelessness:

- A well-rounded homeless policy must be three-tiered: prevention of homelessness, provision of emergency shelter and social service needs for the homeless, and transitional housing for those already in shelters.

- Since most homeless families usually find emergency shelter, they are not as visible as the homeless living on city streets. State governments can elicit private support for homeless shelters and educate the public about family homelessness through public information campaigns.

- Many homeless families are the "working poor" who had an event, such as a job loss or illness, push them over the edge of self-sufficiency.

- Homelessness is now recognized as the end product of an increasingly inadequate rental housing supply. According to the Maine PATH program, "homelessness remains substantially an affordable housing crisis."

- Housing and homelessness represent gaps in our nation's welfare system. To ameliorate this problem, state and federal governments need to coordinate housing and social service policies and objectives.

- Thousands of American teenagers experience the double bind of being pregnant and homeless. These young people are often reluctant to seek help from public agencies due to concern about losing their children.

- Child welfare and family preservation are strongly affected by family homelessness. A New Jersey study found that homelessness or extreme housing difficulties were the primary cause of a child's placement in foster care for more than 40 percent of families with children in care.

- There are four types of homeless families: unemployed two-parent families, mothers leaving abusive relationships, AFDC mothers, and mothers who had been homeless teenagers. Each of these groups requires different types of assistance.

- All homeless families require access to a variety of services other than housing. Many homeless families are disconnected from supportive relationships and caretaking institutions. Families may need child care, transportation, food stamps and welfare, medical and mental health services, and vocational training. Shelter programs must be able to handle referrals to a variety of agencies to help homeless families regain self-sufficiency.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to prevent family homelessness and to provide shelter and social services for already homeless families:

- **Establish special grant or loan programs to assist in renovation and new construction of housing for homeless persons.**
- **Amend welfare programs to ensure ongoing support for persons unable to work or unable to locate work.**
- **Require that homeless families receiving AFDC be housed in decent, safe, and sanitary units. Increase coordination between state social services and housing departments to monitor this requirement.**
- Provide rent assistance, as in New York, to families at risk of losing their children when lack of housing is the only impediment to maintenance of custody.
- Investigate continuous, rather than emergency, funding sources for homeless programs. Homelessness may be a temporary problem for families, but it is an ongoing and increasing national problem.
- Create a transitional housing program for pregnant and parenting teenagers or for single-parent families.
- Use legislative oversight to promote interagency agreements between agencies that work with homeless clients, such as that which Massachusetts has instituted.
- Establish a revolving fund, such as the one in New Jersey, to protect low-income tenants from eviction.
- Create an affordable housing trust fund, such as California's, with a portion of funds earmarked for homeless shelters and transitional housing.
- Explore the feasibility of housing units specially designed for single-parent families, with child care available on-site.

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PAY EQUITY

Commentary

Social and economic changes in the lives of American women have led to a continued feminization of poverty, in part due to the earnings potential currently available to women in the workforce. In 1986, for instance, female-headed households represented over half of all families living below the poverty level. This decline in the economic status of women in part can be attributed to the increase in single-parent families, inadequate child support payments, and high child care costs. However, it also relates to the employment earnings potential for women who are oftentimes unable to care for their families.

Gender or race are too often used as factors to determine one's income. In 1987 American women who were working full-time were making only 65 cents for every dollar earned by an employed man.(7, p. 41) The concept of comparable worth encourages employers to place values on jobs by identifying and weighing factors such as knowledge, skill, and working conditions and to make fair comparisons between job responsibilities and wages.

The subject of pay equity or comparable worth extends beyond the concept of equal pay for equal work in order to address issues of pay discrimination across jobs. Advocates of pay equity assert that jobs should be compensated based on skill level, training, responsibility, individual risk, and working conditions inherent in the job. Dissimilar jobs can be compared upon the basis of such job factors and compensated upon the basis of their overall comparable worth. They further contend that jobs traditionally held by men, such as mechanical work and construction, pay more than jobs requiring similar training and responsibility but traditionally held by women and minorities, such as clerical and health service positions. Many comparable worth advocates believe that many "women's jobs" are underpaid and undervalued purposefully.

In the mid-1960s, for instance, it was common for public employers to mirror private sector pay schedules for many jobs and thus pay positions such as tree trimmer substantially more than professions such as nurse, although the profession of nurse scored much higher on virtually all measures of job worth. The resulting wage differences almost always served to the economic disadvantage of women, who were much more likely to become nurses than tree trimmers. Such findings of wage differences in public employment--at the city, county, and state level--have given rise to a re-examination of public compensation systems for sexual bias.

In 1981 male clerical workers earned $108 more a week than female clerical workers.(6) In 1982 full-time women workers had average annual earnings of $8,063 less than men.(6) Fifty-two percent of women were working full-time in 1984 and bringing home 61 cents compared with every dollar for men.(5, p. 26) The wage gap has narrowed barely 5 percent in more than two decades. Another year of slow progress in earnings for women and minorities underscores the fact that implementing pay equity remains a critical strategy for raising women's wages.

The same wage gaps have been found to exist for minority populations as well, and a small but growing number of states are beginning to examine their compensation systems not only for sexual bias but also for racial bias. In Los Angeles County, for instance, it has been determined that the county pays $33,262 to workers in entry level jobs that are primarily held by whites, but only $17,292 to workers in entry level jobs with similar skill requirements that are primarily held by Hispanics or blacks.(4)

While most states and many local governments have undertaken programs to reduce pay inequities, actions in the United States have not placed any specific comparable worth requirements upon the private sector. Although many private sector employers have recognized comparable worth principles in redesigning their compensation systems, neither the federal government nor any states have mandated that private employers compensate upon the basis of comparable worth (although comparable worth lawsuits have been based upon the provisions of the 1963 Equal Pay Act). Ontario, Canada, however, has taken such action. The legislation it enacted in 1987 to require pay equity implementation in both the public and private sectors promises to be observed well beyond Canada's borders. Also the European Economic Community (EEC), which consists of 12 European countries, is bound to observe EEC provisions of equal pay for work of equal value. To date, a number of cases have been made against countries that fail to include equal pay for equal work in their national legislation.

Federal Policy

Federal legislation that has addressed issues of occupational and pay equity for women workers includes:

- The 1963 Equal Pay Act forbids companies to discriminate in pay for the same job on the basis of sex or race. Since many jobs are sex-segregated, the concept of equal pay does not address many wage differences between comparable (but different) men's and women's jobs. The act defines the requirements that must be met before there can be a decision that a job is "equal work" so as to require "equal pay." These requirements include: both men and women must work in the same establishment; the work must be performed under similar working conditions; the jobs of each must require equal skill, effort, and responsibility; and the work itself must be equal.

- Executive Order 11246, signed by President Lyndon Johnson, requires any employer with a federal government contract not to discriminate. The president later issued Executive Order 11375, which amends 11246 by adding sex discrimination to its prohibitions.

- The 1964 Civil Rights Act and the 1972 amendments to it prohibit discrimination in employment, such as hiring; firing; or setting compensation on the basis of race, color, national origin, religion, and sex.

Nevertheless, in the past 20 years, there has been a decline in women's wages compared with those of men. For the third time in four years, the House of Representatives passed federal pay equity legislation, the Federal Equitable Pay Practices Act, but a similar bill failed to pass the Senate. Congress is likely to come back to the notion of comparable worth. However, most of the big battles over the pay equity issue will continue to be fought in court action and state legislation.

The first federal pay equity case involved the state of Washington. In 1974 the state conducted a pay equity study that identified sex-based wage inequities, as did the follow-up studies conducted in 1976, 1979, and 1980. After years of conflict over pay equity, the American Federation of State, County and Municipal Employees (AFSCME) filed suit against the state. AFSCME charged that the state was discriminating against women by underpaying jobs that are traditionally female dominated. In 1983 a federal court judge ruled that the state was in violation of the Civil Rights Act of 1964 and ordered the state to implement the findings of the study and award back pay from 1980 to approximately 34,000 state employees. The decision was reversed by a higher court. However, Washington agreed with AFSCME to a $101 million pay equity adjustment to be implemented in increments by 1992.

A federal court is also in the process of hearing a California case, which was brought by the California State Employees Association. This case is the largest sex- and race-based wage discrimination suit ever, and its outcome could affect nearly 70,000 present and former state workers.(2, p. 5) The suit charges that the state of California has engaged in pay practices that discriminate by paying less to job classes dominated by women and minorities.

While court cases provided the initial impetus for pay equity adjustments for public employees, these cases, however, have not produced a clear legal right to comparable worth for public or private employees. Most action taken to reduce pay inequities through pay adjustments for female- or minority-dominated job classifications has come through political efforts and changes in public employee compensation policy.

State Policy

Every state, except Alaska, Arkansas, Delaware, Georgia, and Idaho, has taken at least an initial step in addressing pay equity. State activity ranges from the collection of data to full implementation. The National Committee on Pay Equity has identified four levels of pay equity activity:

Preliminary Research/Data Collection. A complete pay equity study has been conducted in 43 states, including the District of Columbia.(4, p. 1) These activities may include monitoring pay equity activities in other states, establishing task forces or commissions, identifying pay gaps between the wages of women and men, and studying the pay equity problem in general.

- In 1984 Arizona collected data on state clerical employees' salaries. Nearly three-quarters of the state's clerical workers received raises from a $3 million inequity fund as a result.

- A Nebraska study to identify occupational segregation and salary inequities was completed by the Legislative Appropriations Committee in 1978. The state collects data on male- and female-dominated job classifications annually.

Pay Equity Studies. These studies ensure that biases are eliminated by examining the jobs and wages in a state's system to determine if sex and race are factors in wage setting. Twenty-three states, including the District of Columbia, have conducted or are in the process of conducting pay equity studies.(4, p. 2) New Jersey, New York, Wisconsin, and the District of Columbia have also examined their compensation systems for racial as well as sexual discrimination.

- A review of the Ohio civil service system in 1984 revealed sex-based wage inequities. In the same year, a task force was established by the governor to conduct a pay equity study. Work on the study was completed in 1988, and money has been appropriated for the pay upgrades. Negotiations for any pay equity adjustments as a result of modifications to the state's job evaluation system, however, are not expected to occur until 1990.

- In 1979 the Maryland Governor's Commission on Compensation and Personnel Policies was created to investigate the state's job evaluation system. The commission, after consultation with the governor, announced it would conduct a pay equity study in 1983. The study was completed in 1985, but the results have never been implemented.

Pay Equity Adjustments. Adjustments have been made or appropriated in 20 states to eliminate pay discrepancies in state employment based on sex or race.(4, p. 2)

- In Florida $3.8 million was appropriated in 1987 to adjust the pay for state and university employees in female-dominated positions.

- A New Mexico task force was appointed by the governor in 1985 to study pay equity; it evolved into a job evaluation task force, which conducted a pay equity study. Adjustments were made to salaries in 23 female-dominated classifications in the lowest pay ranges through a prestudy appropriation of $3 million.

Implementation of a Pay Equity Plan. Implementation of a pay equity plan for state employees has taken place in six states. Iowa and Minnesota are the only states to implement their plans fully. Other states that are in the process of completing their plans are Connecticut, New York, Washington, and Wisconsin.(4, p. 2)

- Iowa has implemented comprehensive pay adjustments based upon comparable worth for its executive branch, legislative branch, and judicial branch employees. Approximately $30 million annually was added to general fund appropriations to make these adjustments, which positively affected more than 10,000 state employees. The result was an increase to virtually all of the lowest paid, female-dominated job classifications in the state, although mixed and male-dominated job classifications in some instances were upgraded as a result of the study. One of the most telling findings from the classification study was that, even after 13 "job factors" related to job worth were used to explain the existing pay structure, a 14th "job factor"--the percentage of women in the job classification--could explain a substantial additional difference in pay. On average, by this measure, a job held entirely by men had a starting salary of $1,700 more annually than a job of comparable worth held entirely by women. Implementation of comparable worth in Iowa eliminated this difference.

- Minnesota has implemented comprehensive pay adjustments based on comparable worth for its executive branch employees. The Task Force on Pay Equity studied salary differences among state employees. Funds for pay adjustments were added to the general appropriations. Between 1982 and 1984, more than 9,000 state employees received equity increases of $1,600 each. It remains to be seen whether the adjustments will affect the private sector.

- Recently, Minnesota also has enacted laws that provide financial penalties for cities, counties, and school districts that fail to implement pay equity.

Key Points

In examining the problem of pay equity, the following points need careful consideration in the development of sound public policy:

- Women's labor force problems are twofold. First, occupational segregation keeps many women in low-paying jobs. Second, even when women move into higher level jobs, gender-based salary differences persist.

- Factors considered in pay equity studies include: amount of knowledge or skill; mental or physical effort; responsibility; working conditions; amount of education; and stress.

- Pay equity affects women and minorities. In 1987 the pay gap was measured by comparing one dollar of earnings by white men who work full-time with the earnings of other full-time workers. The results are as follows: black men--71 cents; Hispanic men--65 cents; white women--63 cents; black women--57 cents; and Hispanic women--53 cents.

- **Female-headed households represent an increasing share of families in poverty. In 1986 51.4 percent of families below the poverty line were female-headed, single-parent families. Pay equity programs are needed to reverse this trend and enable women to support their families.**

- **Model pay equity programs exist in Canada and Europe. These programs require careful analysis in order to implement similar programs in the United States.**

- **Legislative involvement in pay equity activity varies from state to state. Some state initiatives come from within the personnel system, while some state legislatures have initiated pay equity action. In a few states, advocacy groups, such as unions or women's groups, have brought the issue to public attention.**

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action for pay equity policy:

- Continual assessment of pay gaps between wages of men and women and ethnic or minority groups doing comparable work.

- A pay equity study for all public employees, if one has not already been conducted.

- Implementation of the recommendations from state pay equity studies, in those states having completed a survey.

- Stronger enforcement of equal employment laws that prohibit wage discrimination.

- The enactment of additional legislation to guarantee equal pay for equal work.

- The expansion of job opportunities for women in male-dominated fields by increasing job training opportunities for women workers.

- Study methods that would encourage private sector employers to participate voluntarily in pay equity studies and programs.

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CHILD CARE

Commentary

The demand for child care is growing as the number of women working outside the home increases. In 1987, 57 percent of women with children under six worked outside the home--a 45 percent increase since 1960. The fastest growing segment of the workforce is mothers with very young children. Over half of working mothers return to work before their child's first birthday.(10)

Mothers are working outside the home to support their families. About two-thirds of those mothers are either single, widowed, divorced, or have husbands who earn less than $15,000 per year.(6, p. 51) Single mothers in the labor force number 3.5 million. Dual-income families exist, in part, because of the decreasing number of jobs that allow a head of household to support a family.

Parents must have accessible and affordable child care in order to work. Unfortunately, affordable, quality child care is often difficult to find, and many parents report frequent breakdowns in their child care arrangements. Inadequate child care interferes with entry into the labor force and hinders parents' advancement and personal productivity. Unemployed and underemployed parents, whose income is insufficient to meet family needs, warrant special assistance in finding affordable child care.(3, p. 20)

Cost of Child Care. Child care is expensive at all economic levels, generally coming after food, housing, and taxes as the fourth largest budget item for families with children.(5, p. 2) It comprises 10 percent of most working families' budgets. For families with two children under six, it can consume 30 percent of the budget.(6, p. 37) Families spend an average of $3,000 per child per year for full-time child care, which is equivalent to one-third of the income for a family of three at the poverty level.(5)

Child Care and Public Assistance. While the cost of child care can be a problem for families who are working, it can be prohibitive for families who struggle to escape welfare dependency. Child care can enable AFDC recipients to register and participate in work training programs. Lack of satisfactory child care arrangements can influence the ability of welfare recipients to find and keep a job. For participants in state welfare-to-work programs, "transitional child care," the extension of child care assistance beyond the training period, is a key element in maintaining successful job placement. Child care is also essential for displaced workers who must develop new skills as the nature of the job market changes.(3, p. 26)

Special populations at risk of welfare dependency need child care to become self-sufficient. Teenage parents who have not yet completed high school, parents who are working toward finishing their GEDs, and parents with limited English-language proficiency need child care.

Federal Policy

The federal government sponsors programs that provide some child care assistance. The cost of these programs runs close to $6 billion annually. However, there is no coordinated approach to program content.

Head Start. Developed in 1964, Head Start is the only federal program that supplies direct child care services as part of an early childhood education program for preschoolers. Eighty-five

percent of those services are on a part-time basis. Eligibility for the program is tied to the federal poverty level. Although 430,000 children participated in 1986, only 16 to 20 percent of the eligible children were served.(4, p. 2)

Social Services Block Grants. Title XX Social Services Block Grant (SSBG) money is a major form of federal support for child care. States are eligible for these funds and may use them to subsidize child care services as well as other support services for low-income families. States decide the percentage to be used for child care, and most states require recipients to be enrolled in training or education programs in order to receive child care.

Federal Tax Provisions. The federal government subsidizes child care through the Dependent Care Tax Credit by allowing families to subtract between 20 and 30 percent of their child care expenses from their tax liability. This tax credit makes up 60 percent of the federal support for child care services in the country.(6, p. 39)

Welfare Reform. The Family Support Act of 1988 includes several child care provisions. Public assistance recipients with children over three will be required to participate in state-administered job training programs. States have the option of requiring participation of parents of one- and two-year-olds. States are mandated to guarantee child care for participants in education and training activities. In addition, states must offer transitional child care services to families for up to 12 months after the last month in which the family received assistance. States may provide child care services directly, arrange child care through purchase of service contracts or vouchers, provide cash or vouchers in advance to the family, reimburse the family in cash or through use of the child care disregard, or use other arrangements determined appropriate by the state. The costs of child care are matched at the state's Medicaid benefit matching rate, which currently ranges from 50 percent to approximately 79 percent. States are required to implement the program by October 1, 1990.

State Policy

State child care policies focus on increasing accessibility, affordability, and quality of child care services. State programs continue to emphasize services to low-income families. State child care policies are generally fragmented and reflect a combination of federal and state priorities. States have passed legislation providing for child care subsidies, tax credits or deductions, state employee child care, loan and grant programs, resource and referral services, and training for child care workers.

Assistance for Low-Income Families. Building on federal programs, states provide direct assistance to reduce child care costs through subsidies to lower income families. A majority of states use part of their federal Social Services Block Grant money to fund child care subsidies for low-income families. In most cases, eligibility for SSBG subsidies is based on state eligibility standards for AFDC or Supplemental Security Income.

State SSBG child care assistance is generally allocated in the form of vouchers to parents or reimbursements to providers and administered using a sliding fee scale based on family income and number of dependents. States such as Iowa and Wisconsin provide additional state dollars to supplement federal SSBG child care funds. States also take advantage of the federal child care disregard, which allows AFDC recipients to deduct child care expenses in the calculation of their monthly benefits.(2, p. 3) Under the Family Support Act of 1988, the monthly allowances are $175 per month for children two and over and $200 for younger children.

Several states, including Alaska, California, Massachusetts, Minnesota, New York, and Rhode Island, provide money for state programs based on a sliding fee scale. In most cases, these funds are available to low-income families whose incomes exceed the SSBG limits. State and federal sliding fee scale subsidies are graduated so that families earning higher incomes receive lower subsidies.(2, p. 2)

Several states provide funding or other support for child care for children of teen parents to encourage them to complete high school (California, Connecticut, Florida, New York, Pennsylvania, Texas, Rhode Island, and Wisconsin). Michigan, through its Young Parent Program, guarantees child care assistance to any parents under 21 years of age to enable them to finish high school, attend adult basic education, or earn a GED.(3, p. 31)

Some states (California, Minnesota, New York, North Carolina, and Wisconsin) provide child care support for low-income parents in post-secondary training and education programs. In 1987 Minnesota also authorized a state bond issue to build 16 day care centers at technical schools and community colleges.(11, p. 89)

Child Care in Welfare-to-Work Programs. Under the Family Support Act of 1988, states will be required to guarantee child care to participants in education and job training programs by October 1990. One year of transitional child care assistance must be made available to AFDC families who lose their benefits due to employment.

Before the passage of the act, 18 states already provided child care support for welfare recipients in work training programs. Many of these states also offered transitional child care, ranging from three to 18 months, after completion of the training program and the beginning of employment. Participation requirements for parents of young children in these programs differed among the states. Most states required parents to participate if they had children older than age six.(7, pp. 3-4) It was this sort of state activity that provided a model for the federal legislation.

States will build on these experiences when implementing programs under the federal legislation. However, the states need to make several decisions. For example, they have the option of requiring parents of one- and two-year-olds to participate. Licensing and quality issues also need to be decided. States have the option of providing quality early childhood education experiences to those low-income children who can benefit most from early intervention. In addition, to receive federal reimbursement, states may choose to pay for child care at a rate between the floor and the ceiling set by federal law.

Tax Credits and Deductions. Many states provide indirect child care assistance to families and corporations through the tax code. Half provide assistance to families with child care expenses through state income tax credits or tax deductions. In most instances, the state child care tax provisions are tied to the federal child care tax credit. The federal program enables parents to claim income tax credits for child care expenses up to a maximum of $2,400 for one child or $4,800 for two or more children. State child care tax credits range from 10 percent of the federal credit in Arkansas to 50 percent in Hawaii. Minnesota, New Mexico, and Oregon provide refundable credits to parents who do not earn enough to be liable for taxes. Several states, including Montana and Virginia, permit parents to deduct child care expenses from their state income taxes. Although most states restrict deductions to a portion of the amount spent on child care, Idaho permits families to deduct 100 percent of their child care expenses.(2, p. 3)

States also provide indirect assistance through the tax code by providing incentives to employers to assist with child care. Fifteen states offer incentives to employers that support employee child care needs. Connecticut enables companies to earn corporate investment or renovation credits for contributions to child care facilities used by their employees. The state also provides a tax credit for companies that subsidize their employees' child care expenses. Similarly, Oregon provides a 50 percent tax credit to corporations that provide or pay for child care services for their employees. In addition, Arizona, California, Florida, New Mexico, and Oregon utilize credits or deductions for start-up or equipment costs in on-site facilities; California permits extended amortization and depreciation of expenses; and Pennsylvania provides employment incentive payment credits.(9, p. 5)

Child Care for State Employees. Two-thirds of the states either provide or are planning to provide child care assistance for state employees. Fifteen states, including California, Florida, New York, Ohio, Utah, Washington, and Wisconsin, provide on- or near-site care for children of their employees. Many other states, including Kentucky, Pennsylvania, and Vermont, support resource and referral efforts that assist state employees in locating child care services. Still other states directly defer child care costs for state employees. For example, Illinois offers child care reimbursements, and Oregon offers employees the option of using the federal income reduction plan. In this case, the employee's salary is reduced by a specified amount of money that is then used for child care. This money is tax free for the employee and also for the state.(1, p. 4)

Loans and Grants. To reduce the costs of providing child care and to expand the supply of providers, some states offer loan or grant programs for start-up, construction, or renovation expenses. California provides interest-free loans; Connecticut provides low-interest loans; and Illinois and Maryland also fund loan programs for providers. In addition, Massachusetts provides low-interest loans for start-up costs for employer-sponsored child care facilities. Rather than provide loans to providers, Oregon offers grants for physical improvements; Rhode Island funds a grant program for private, nonprofit providers operating child care facilities in industrial parks.(8, p. 2)

A few states, including New York, Pennsylvania, and Vermont, provide funds for recruitment of child care providers. California's Child Care Initiative provides for the recruitment and training of family day care providers. Technical assistance is available to providers to help them through the rigors of licensing and business management.(8, p. 4)

Resource and Referral. The most common state strategy for increasing accessibility of child care is the establishment or funding of resource and referral systems (R&Rs). R&Rs serve a variety of purposes and are generally operated by independent, private entities. Often, they provide a resource bank of child care services available in a particular locale. R&Rs match a parent's child care needs with the services available.

R&Rs often provide additional services including training and technical assistance for providers; information on options for employer-supported child care; access to resource lists for businesses, the public, and advocates; and periodic assessment of the changing characteristics of the child care market in specific locations.

Several states fund R&Rs. California supports a statewide network of locally administered R&Rs under the California Child Care Resource and Referral Network. Recently, New York appropriated over $2 million to help parents find care, providers with training and licensing, and employers whose employees need care. Arkansas, Iowa, Massachusetts, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, and Washington are among other states that provide money for R&R services.(8, p. 5)

Quality in Child Care. Quality child care programs have positive results on the development of young children. Minimum child care standards are established and enforced through the state regulatory system. The most important factor in a quality child care program is the competence, knowledge, and dedication of staff. Increasing staff salaries may reduce turnover and aid in the recruitment of trained personnel. Connecticut, Maine, Maryland, Massachusetts, Minnesota, New Jersey, and Pennsylvania recently provided funds to raise staff salaries in qualifying child care centers. A related strategy for promoting quality is to help finance training for child care providers. Connecticut funds a cable television training series, and Rhode Island provides state dollars for training and resource development for non-English-speaking family day care providers. Other states spending money on training include Massachusetts, Minnesota, and New York.(2, p. 4)

Key Points

The following key points merit consideration when developing sound child care policy:

- **The demand for child care is growing as the number of mothers in the workforce increases. Today, 57 percent of mothers with children under six years old work outside the home.**
- **Child care is expensive, averaging $3,000 per child per year for full-time care. Quality care is difficult to find and arrangements can often break down.**
- **Affordable, accessible, quality child care is essential for working parents.**
- **Quality child care programs have positive effects on the development of young children. Quality indicators include low staff/child ratios, low class size, and staff trained in child development.**

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to increase the supply and accessibility of quality child care services to parents in the states:

- Make child care affordable to low- and middle-income families by:
  - Providing direct subsidies to low-income families;
  - Providing tax credits or deductions for child care expenses;
  - Providing tax incentives to employers who assist their employees with child care;
  - Offering direct child care assistance for state employees; and
  - Funding child care assistance for teenage parents, including school-based child care programs.
- Expand the supply of child care by:
  - Offering loan or grant programs for start-up, construction, or renovation of child care facilities;
  - Providing tax incentives for facility expansion or renovation;
  - Offering direct assistance to providers to help pay for operating costs, including liability insurance; and
  - Establishing school-age child care programs.
- Increase the quality of child care for healthy child development by:
  - Funding salary increases for child care providers in state-operated programs--to attract and retain providers; and

- Raising the status of child care workers through training programs and salary increases.

- Provide financial support to resource and referral networks to assist families in locating child care, provide training for providers, and assist employers in defining and implementing strategies for helping their employees with child care.

- Encourage the federal government to implement a coordinated child care program with increased funding.

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FAMILY LEAVE

Commentary

Family leave has become a controversial public policy issue in this age of two-wage-earner families. According to the Bureau of Labor Statistics, in 1987 33 million women were in the workforce, and 75 percent of those women will become pregnant sometime during their career. These women work for wages needed in modern American families. In 1984 the American Medical Association admitted that its previous recommendation that women stop working in their sixth month of pregnancy was based more on myth than science. A majority of women work into their ninth month of pregnancy.(6, pp. 29-31)

During the 1950s, 75 percent of American families had a father who worked outside the home and a mother who worked at home to care for the children. In 1987 only 10 percent of American families reported this work pattern. Over half of mothers with children less than one year old are working or seeking employment.(8, p. 1) Consequently, all people of child-bearing age have an emotional and economic interest in the issue of parental leave.

Studies show that women tend to work in lower-paying jobs and industry sectors, and for smaller firms. Consequently, averages by the Bureau of Labor Statistics that indicate that about half of American companies offer short-term disability insurance are probably higher than what women as a group actually receive because of the lack of information gathered on this issue. Also, having paid maternity leave does not guarantee any other benefits, such as health care or a job upon being ready to return to work.

In a 1987 poll conducted by the *Wall Street Journal* and NBC News, 52 percent of Americans agreed that companies should be required by law to let men and women take up to 18 weeks unpaid leave from work after the birth or adoption of a child. In the case of a seriously ill child, 72 percent felt that family leave should be available.(2)

Child development research stresses the importance of a "bonding" period in establishing a secure parent/child relationship as the foundation for solid long-term emotional development. Time off from work allows parents and infants to form attachments, establish sleep and feeding patterns, and reorganize the familial living patterns.

Often, a state's family leave policies determine a family's options. For example, infant care for babies younger than three months is almost impossible to find. Young families may be forced to choose between working and caring for their new babies.

Concern for a child's development and lack of available infant child care are accentuated by working parents' economic interest in parental leave policy. According to recent research from the Institute for Women's Policy Studies, job-protected parental leave can help reduce unemployment rates and minimize wage loss for women returning to work after childbirth. Lack of adequate parental leave costs families and taxpayers approximately $363 million each year. Costs include $225 million in lost wages and $108 million in public assistance income, such as unemployment insurance, food stamps, and AFDC. In a three-year period, women who gave birth lost nearly $31 billion in earnings. Of that amount, $607 million was due to the lack of family leave or reemployment rights.(9, p. 1) In addition, businesses have made a major investment in the training of women currently in the

workforce. Proponents of parental leave urge businesses to protect that investment by ensuring leave for employees who become new parents or have an ill relative to tend.

A comprehensive policy on family leave includes family members other than new parents. The issue has become intergenerational. Wisconsin recently passed legislation that requires employers to provide two weeks of unpaid leave for workers to care for seriously ill family members. Allowing family members time from work to respond to family crises actually improves an employee's attitude and job performance. Experts contend that approximately 80 percent of long-term care for the elderly is provided by family members. A General Accounting Office (GAO) report estimates that $5 billion in income is lost each year to care for elderly relatives, with a resulting $379 million paid in transfer payments.(5)

Federal Policy

U.S. family leave policy lags far behind that of the rest of the world in that the United States is the only industrialized nation that does not provide workers with some form of job-guaranteed leave for the care of new or ailing family members. Approximately 135 countries pay workers during leave for childbirth. Similarities between the U.S. and Japanese workforce include rapidly expanding female employment. In 1984 nearly half of Japanese women worked (only 3 percent less than American women), and 60 percent of leave salary was paid by the government, with national health insurance coverage available for all. The Japanese business community recognizes that family support policies are good for children, families, and the national economy.(9, p. 6)

On the federal level, attempts to adopt a national family leave policy have culminated in the Family and Medical Leave Act of 1987, as amended. This act allows employees to take up to 10 weeks of unpaid leave over a two-year period upon the birth, adoption, or serious illness of a child or parent and up to 15 weeks every two years for their own illness. Upon returning to work, the employee is guaranteed the same, or an equivalent job. In the first three years after enactment, businesses employing 50 or more people are subject to the legislation. Thereafter, firms employing more than 35 people will be required to provide these benefits. In addition, the legislation also requires employers to continue health benefits for workers while on unpaid leave at the same level as if the employee were still working. However, it does not require continuance of other employee benefits. To qualify for unpaid leave, a worker must have been employed in the work situation for at least 20 hours per week for one year. The highest paid 10 percent, or top five employees, whichever is greater, may be excluded from coverage.(5, p. 8)

The GAO reports that little expense will be associated with replacing workers or maintaining production while workers are on unpaid leave. Businesses replaced fewer than one-third of their workers, and the cost of replacements was often less than that of the employees being replaced. Oftentimes, worker's schedules are shifted and rearranged to accommodate an employee on leave. Costs for the legislation are an estimated $188 million annually for businesses with 50 or more employees and $212 million for those with 35 or more employees. This is the price of maintaining health insurance during employee absences.(5, p. 10)

Opposition to family leave legislation comes from the business community, especially from those who run small businesses. They argue that hiring replacement workers is expensive, that unemployment compensation taxes can be affected due to laying off replacement workers when the employees return to work, and that government should not impose mandates on business.(1)

State Policy

In response to public support for family leave, state legislatures are taking the initiative in developing guidelines for employers. In 1988 alone, almost 100 bills relating to maternal disability or family leave were introduced in 32 state legislatures across the country. Prior to 1987, no state

required employers to offer job-guaranteed parental leave. By the end of the 1988 legislative session, Connecticut, Maine, Minnesota, Oregon, Rhode Island, Washington, and Wisconsin did require or were considering it.

California passed a parental leave bill that required employers of 25 or more workers to grant 16 weeks of unpaid leave for childrearing, but the governor vetoed it. Employers in California and elsewhere, however, increasingly are supportive of family leave policy. With almost 90 percent of the first year's salary being the cost of recruiting, hiring, and training the employee, business leaders are questioning the wisdom of not maintaining their investment in valuable employees.

Tennessee enacted a law in 1987 that required employers of 100 or more full-time employees to allow up to four months paid or unpaid leave to female workers upon the birth or adoption of a child. The state attorney general questioned the constitutionality of the law that excluded male employees from leave not directly related to physical disability caused by pregnancy. In the 1988 session, the legislature revised the statute to make it apply "for pregnancy, childbirth, and nursing the infant." The legislation now seems more accurately to provide "maternity-disability leave," a job protection for the physical disability associated with childbirth.(4, pp. 13-14) Maternity-disability leave legislation has been enacted in California, Connecticut, Iowa, Louisiana, Massachusetts, Montana, and Nevada. Federal law also requires disabilities arising from pregnancy to be treated like other disabilities.

Massachusetts is the only state that has proposed paid parental leave. Pending legislation would provide 18 weeks of job-protected leave for mothers and fathers at the birth or adoption of a child. For 12 weeks, parents on leave would receive pay equivalent to approximately 60 percent of their salary but no more than 66 percent of the state average weekly wage. The wage replacement fund would be created from a general payroll tax.(9, pp. 1 and 3)

The Washington Legislature established an annual leave sharing program for state employees in 1989 to help state employees who suffer or have family members who suffer from serious, long-term illnesses and exhaust available leave time from work. These employees often have to take unpaid leave or terminate their employment, which causes further stress to a traumatic family situation and creates costs to the state in training new employees. The leave contribution program is established for state employees, including agencies, school districts, educational service districts, colleges and universities, and the legislature. The program permits employees, at no significant increase in the cost of providing annual leave, to transfer annual leave to another employee. The recipient employee must have an extraordinary or severe illness or injury or have a family member with such a problem; have depleted or nearly depleted all leave reserves; have diligently attempted to accrue sick leave; and be ineligible for industrial insurance benefits. The leave may not exceed 261 days, and the donating employee cannot request a transfer of leave that would result in his or her annual leave falling below 10 days.

Other states that have enacted legislation requiring unpaid job-protected family leave include:(3)

- *Connecticut*--24 weeks of leave for birth, adoption, medical disability, and ill child/spouse/parent for all public sector employees; health coverage is continuous; a task force on private sector involvement was created.
- *Maine*--eight weeks for birth, adoption, ill child/spouse/parent for all businesses with more than 21 employees; fringe benefits are continued at employee expense.
- *Minnesota*--six weeks for birth, adoption (mothers and fathers can use concurrently) for all businesses with more than 21 employees; health coverage is continuous.

- *Oregon*--12 weeks for birth or adoption for employers with more than 25 employees; exempts employers who offer "cafeteria" benefit plans with a parental leave option.

- *Rhode Island*--13 weeks for birth, adoption, or ill child for all private sector employers with 50 or more employees and for all public sector employers with more than 30 employees; the employer must reimburse workers for fringe benefits paid during the leave.

- *Wisconsin*--six weeks for birth, adoption, or ill family member for all businesses with more than 50 employees; employees may be required to pay for health insurance in escrow.

Key Points

In examining the problem of parental leave, the following points need careful consideration in the development of sound public policy:

- A majority of women are employed in the United States, and three-quarters of these women will become pregnant sometime during their career.

- Only 40 percent of all working women in 1984 had paid maternity/disability leave.(6, p. 30)

- The average amount of time that women take off as a result of childbirth ranges from six to 12 weeks, and most of that time is medical disability leave; a majority of women work into their ninth month of pregnancy.(6, p. 29)

- The developmental needs of newborns require a period of bonding for infants and both parents as a foundation for a healthy and productive life, and new parents should not be forced to choose between caring for their children and working.

- The U.N. Economic Policy Council, United Nations Association--whose members include union presidents, corporate executives, and academics--recommends that all women workers be guaranteed a minimum of six to eight weeks' job-protected maternity leave with partial income replacement and an unpaid, but job-protected, leave until the child is six months old.(6, p. 31)

- Most companies do not keep formal records of employee requests for family leave or the number of women who do not return to their original jobs after maternity leave.

- The Yale Bush Center in Child Development and Social Policy, Advisory Committee on Infant Care Leave--whose members include academics and professionals in child development, business, health, social welfare, and law--recommends that leave be available for a minimum of six months with 75 percent income replacement for three months and full benefit continuation and job protection for six months.(6, p. 31)

- Part-time employees rarely receive parental leave benefits. Those part-time employees who are eligible for benefits often do not receive as many benefits as full-time employees do.

- As the aging of America occurs, more employees will be responsible for caring for elder relatives.(7)

- The January 1987 U.S. Supreme Court decision of *California Federal Savings and Loan v. Guerra*, which upholds a California law that provides for up to four months of pregnancy disability leave, is beginning to have a significant effect on state response to parental and family leave.(6, p. 31)

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action for sound public policy on family leave:

- Study state demographics to determine the potential need for family leave policies and its effect on the community, and require all employers to document family leave taken by employees.
- Take a leadership role in identifying state goals for supporting families in the workplace and enacting family leave legislation.
- Enact legislation that permits state employees to take up to 18 weeks of unpaid leave for the birth, adoption, or serious illness of a child or parent.
- Guarantee the same, or an equivalent, job to a state employee returning to work after taking family leave.
- Consider the continuance of state health benefits for state workers taking unpaid leave on the same basis as if the employee were still working.
- Explore the feasibility of paid leave for the birth, adoption, or serious illness of a child or parent of a state employee.
- Consider family leave benefits for part-time state employees on a pro rata basis.
- Encourage the private sector to adopt family leave policies and involve it in family leave public policy discussions.
- Evaluate the effect of mandatory family leave policy on the private sector.
- Consider the imposition of a general payroll tax to fund paid leave for the birth, adoption, or serious illness of a child or adult family member.

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JOB TRAINING AND RETRAINING

Commentary

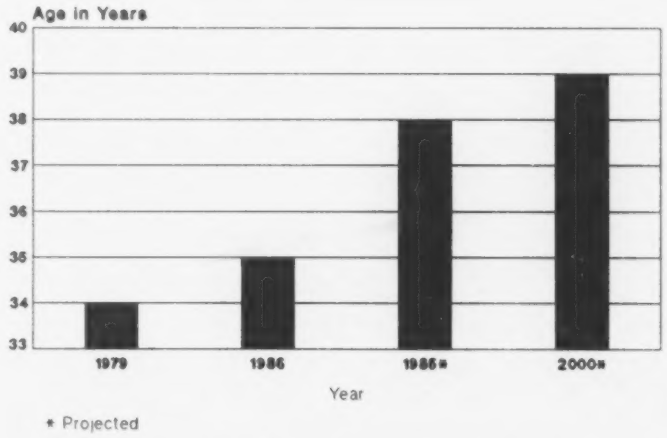
The nation is facing a serious labor crisis. The jobs that have traditionally been available are not in demand, and the U.S. business community has voiced concern that there will not be enough workers to produce the nation's goods and services at the turn of the century. At one time, extractive and manufacturing industries accounted for more than 50 percent of total employment. These jobs provided stable and relatively well-paying careers for workers. Today, these jobs account for less than 30 percent of total employment in the United States. Manufacturers produced 30 percent of all goods and services in 1955 and 21 percent in 1985, and manufacturing's share will drop to less than 17 percent by the year 2000.(7, p. xvii)

The economy has expanded and will create 25.6 million new jobs between 1982 and 1995.(3, p. 7) The vast majority of these jobs is in the service sector--jobs in communications, health care, computer applications, retail and food service. By and large, service sector jobs do not provide the high pay and stability that characterized jobs in extractive and manufacturing industry. The seriousness of the situation is complicated by the tremendous technological changes that are occurring. Experts estimate that workers will average seven to nine job or career changes during their working lives. Consequently, the public and private sectors will be forced to dedicate more resources to train new workers and to retrain older workers.

While the nature of jobs changes, so too does the nature of work. Manufacturing and extractive industries required a willing mind and a strong body. The jobs of today and tomorrow generally will involve less physical labor and will rely more on people and information analysis skills. In any case, new jobs will require one or more years of post-secondary education or training.

Figure 4.

Median Age of Labor Force



* Projected

Source: Video resource guide for "Vocational Education and Human Resource Development." National Conference of State Legislatures, 1989.

The workforce itself is changing. The average age of the American worker is expected to rise from 36 to 39 in the next 10 years.(7, p. xix) At the same time, the decline in our birth rate has slowed the growth of the workforce. Approximately 75 percent of the workforce of the 21st century are already employed. New entrants into the labor force will be overwhelmingly female and from minority groups. Generally, the size of the workforce will not keep pace with the creation of new jobs.

These trends are substantiated by the many employers who are already finding it difficult to recruit new workers. Labor markets are particularly tight in the New England states and in metropolitan centers such as Boston, Washington, D.C., Los Angeles, Atlanta, and Greensboro. This foreshadows the crisis that awaits us within the decade. The country is experiencing a shortage of skilled workers such as nurses, laboratory technicians, and machinists. As the number of new workers continues to fall, businesses will be working throughout the 1990s on new strategies to develop the labor force that they will need for the 21st century.

Policymakers will continue to address the problems associated with shrinking labor markets, which will have surprising results for U.S. working men and women. Issues once defined as social problems are suddenly becoming economic problems. For example, in a tight labor market employers have a greater incentive to reach out to minorities and other disadvantaged groups, to ensure a healthy and safe workplace, and to address workers' obligations to their families. Faced with the increasing competition for well-trained, reliable workers, employers who do not develop sound work policies that incorporate family needs will simply lose out to employers who do.

In addition, the passage of the Family Support Act of 1988 and its emphasis on training welfare recipients to achieve self-sufficiency underscore the importance of job training and retraining on public policy agendas throughout the states. Policymakers will want to ensure that young people are able to participate fully in the economy as young adults. They must possess, however, the basic skills and the willingness to participate. Policies directed at enabling youth, especially teenage parents, to achieve their high school diplomas or equivalencies and strengthening vocational education programs in the states will help meet the labor market needs of the future.(5)

States also face the problem of retraining workers for new occupations. Technological advances have changed the character of the workforce by replacing some employees with machines and by revolutionizing the production, distribution, and use of information in this country. Of the 75 percent of today's workers who will still be on the job in the 21st century, many do not have the basic skills they need to function in their current jobs, much less those of the future. An estimated 30 million workers will have to be retrained in the next 12 years. While retraining will be costly, failing to retrain will be even costlier.(1)

Federal Policy

While most job training takes place in the private sector, the federal JTPA is the major public job training program. The act establishes training programs to prepare unskilled youth and adults for employment. It contains special provisions for summer youth employment and training programs, dislocated and older workers, native Americans, migrant and seasonal farmworkers, and veterans. JTPA targets the economically disadvantaged for training and skills development. The section of the act devoted to retraining workers is budgeted at $400 million. The private sector already spends an estimated $30 billion yearly for training and retraining. In addition, JTPA's programs use a variety of strategies to meet the diverse needs of eligible participants, including classroom training, on-the-job training (OJT), work experience, and job corps.(3, pp. 3-12)

JTPA gives states and their legislatures a substantial role in directing the policy of employment and training programs. Because job training policies must be closely coordinated with other programs, such as education, labor market information, and job placement, JTPA also contains

amendments to the Wagner-Peyser Act, the Social Security Act, and the Carl D. Perkins Vocational Education Act to implement its goals.(3, p. 4) The 1988 Family Support Act requires the states to coordinate the new JOBS program for AFDC recipients with JTPA. (See the section "Family Welfare Policy and Welfare Reform" for an explanation of the JOBS program.)

A key provision of JTPA is the delivery of local services through agreements by the public and private sectors. Two issues have emerged in implementing the law: 1) definition of state and local responsibilities; and 2) definition of public and private sector responsibilities.

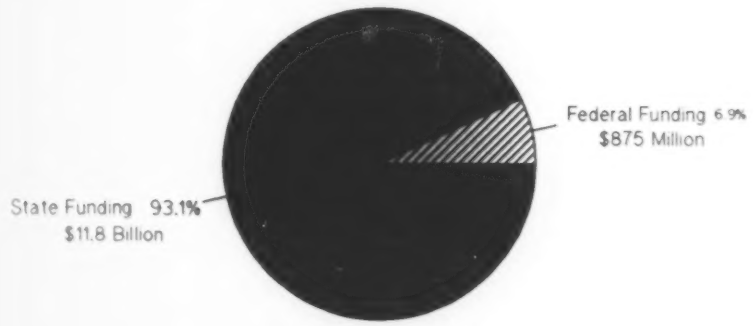
The law requires that each state evaluate JTPA programs by measuring "performance standards." The U.S. Department of Labor has identified specific measures that the states must adopt as a management tool to determine the performance in each service delivery area (SDA) in the state. However, these measures do not allow for an individual assessment of the effect of the program on participants. One of the more controversial issues in implementing the law has been the definition of performance measures and how to make them operational.(3, pp. 12-13)

The only remaining national programs to train and retrain the adult population are the vocational training components of the technical and community college system. The federal government appropriates only $875 million, or 6.9 percent, of the $12.6 billion vocational education budget, which includes secondary school programs as well. The states pay the majority of the vocational education costs.(6, p. 7)

Figure 5.

Federal Versus State Funding for Vocational Education

FY 1988



Source: Video resource guide for "Vocational Education and Human Resource Development." National Conference of State Legislatures, 1989.

State Policy

JTPA does not require legislative involvement. However, state policies and practices may demand some legislative participation. In Alaska, Florida, and Hawaii, the governors were required

to seek legislative approval to reorganize executive branch agencies to administer the program. In other states, the legislature permits the governor to allow state monies to be used to match federal funds as required, although Mississippi has encouraged the use of in-kind contributions. In 1986, 22 states had statutes governing JTPA programs. This number does not include states that appropriated JTPA monies, which is potentially a more influential activity than taking statutory action. State enabling legislation for JTPA contains at least the following points:(3, p. 57)

- Statement of purpose specifying the goals of JTPA in the state;
- Specification of state administrative authority for program operation;
- Legislative representation on the State Job Training Coordinating Council (SJTCC);
- Legislative procedures for review of state coordination and private industry council (PIC) plans;
- Clarification of conflict of interest for SJTCC and PIC members;
- Legislative use of SJTCC for policy recommendations, e.g., coordination of resources, relation of training to vocational education system, state employment and training needs;
- Specification in law of the "openness" and methods of appeal of issues in state and local plans;
- Guarantees of legislative access to information on the operation of the program; and
- Additional language or program evaluation; definition of key program language and other topics that the legislature considers necessary.(3, p. 58)

States have established their own employment and training programs. Twelve states (Alaska, Delaware, Kentucky, Massachusetts, New Jersey, New Mexico, Ohio, Pennsylvania, Tennessee, Vermont, Washington, and Wyoming) have statutory language on employment and training policy not associated with JTPA. These programs operate solely on state revenues. Other states (California, Illinois, Iowa, Maine, Maryland, Michigan, Minnesota, and New York) also make considerable investment in employment and training activities to extend JTPA efforts as specified by statute. All of this activity is separate from the $9 billion state and local investment in vocational education administered by state education agencies.(3, p. 59)

State employment and training policies are summarized under five general areas:(3, pp. 59-62)

State Youth Conservation/Service Corps Programs. These popular programs have been modeled after the Job Corps, Title IV of JTPA, and the 1930s federal Civilian Conservation Corps (CCC). These programs are usually annual and residential, and participation is targeted to economically disadvantaged youth or young adults. The program can be expensive, but cost-benefit studies show that participation expenses offset other outlays over time.

Economic Development Programs. State economic development legislation often contains funds for training or retraining programs. New Mexico established the Industrial Training Board to monitor these programs. New Jersey established a program separate from JTPA and administered by the state's Department of Labor. This program, coordinated through the state's SJTCC, limits administrative costs to 6 percent. Of the funds appropriated, 94 percent must be used for training. One of the key features of the New Jersey program is the variety of activities it funds: apprenticeship; OJT; OJT and classroom training; program outreach; counseling, orientation, and

assessment; job search; classroom training; career upgrading; customized training; job retention training; support services; and post-termination services.

State Skills Corporations. Massachusetts was the first state in 1981 to create a state skills corporation. Since that time, Kentucky, Minnesota, Pennsylvania, and Washington have developed them. Skills corporations are quasi-public and award grants to educational institutions to train employees for private companies. The companies contribute or match state dollars for training their future workers. Skills corporations do not limit their training to economically disadvantaged individuals. The governing board often includes prestigious gubernatorial appointments who can create a broad constituency for the corporations. The corporations often run seminars and conferences or conduct studies to promote a state's development of its training resources.

State Retraining Funds. California, Delaware, and Illinois have created separate funds independent of both vocational education and JTPA monies to promote retraining of dislocated workers. To form California's Employment and Training Fund, more than $50 million was transferred from the state's unemployment system for training or retraining by reducing the employers' unemployment insurance compensation tax and creating a new training tax. The fund focuses on preventive intervention by identifying workers likely to be laid off or unemployed, funding seminars and conferences, and acting as an economic development tool to bring new industries into the state.

The Illinois General Assembly appropriated seed monies to establish the Prairie State 2000 Fund, an innovative approach to retraining based on employer-paid contributions similar to the state-operated unemployment system. The fund provides qualified workers with a voucher to be used in state educational institutions for training or retraining.

Coordinating State Policies. A major part of state legislative activity in employment and training policy has been to coordinate programs to fit JTPA. Setting up grant diversion programs in welfare, customizing job training in vocational education, fostering apprenticeship programs, mandating participation of unemployment insurance recipients in JTPA programs, and establishing strong state labor market information systems can affect significantly the qualify of a state's workforce.

Montana passed legislation, effective July 1990, to establish a JOBS program under the Family Support Act that is coordinated with the efforts of other job training programs, including contracts with adult education providers. The state auditor and welfare department administrators are required to evaluate JOBS and the effectiveness of coordination.

Key Points

To provide a comprehensive approach to training and retraining workers, the following issues must be addressed:

- Distinct strategies are needed to address job training and retraining needs arising from lack of skills, changes in technology, antiquated worker skills, international competition, plant closings, and the dislocation of workers.

- The federal commitment to training and retraining is limited and likely to remain so.

- The implementation of the Family Support Act and federal vocational education legislation requires states to coordinate job training, education, and human services in the states.

- Congress clearly intended the legislature to be involved in establishing the state's job training programs and has given states broad authority to define the legislatures' involvement.

- There are resources within the state, including federal training monies, vocational education monies, and state economic development funds that provide a basis for a coordinated effort to keep our workforce competitive.

- Liability for JTPA dollars is a state responsibility.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to implement job training and retraining programs:

- Stay informed about the state job training programs by requesting information about state and local activities from each legislative house, reviewing the state's Coordination and Special Services Plan under the provisions of JTPA, and developing mechanisms for effective legislative oversight of the programs.

- To match trainees to jobs, review the state labor market information gathering process to determine budgets of the responsible agencies, payment of data collection, information coordination, data gaps, accessibility to the information, uniformity of the planning cycles and geographic planning areas across agencies, definition of common terms across agencies, use of common demographic and economic projections, coordination of legislative oversight, evaluation of the process, and staff training.

- Conduct an inventory of state job training delivery systems and pass legislation to minimize duplication and inefficiency. A recent study in a midwestern state reported 12 separate job training systems in 12 separate state agencies. (3, pp. 64-65)

- Utilize current data collection systems on state job training programs to determine the most cost-effective implementation strategy for JOBS under the Family Support Act.

- Consider imposing performance standards in the use of vocational education funds for secondary, community, and technical education. Florida recently passed sunset provisions for vocational education programs that do not meet enrollment or training-related placement rates.

- Review the role of the state economic development agency and its funding. Forty-four states already have skills training and upgrading services available as an economic development tool. These programs should be integrated into the state's overall strategy for meeting its workforce needs of the future.

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YOUTH EMPLOYMENT AND SERVICE

Commentary

The transition from economic dependence in school to self-sufficiency through work has become more difficult for today's youth than for any generation since the Great Depression. During 1988 the unemployment rate of youth between the ages of 16 and 19 increased to 16.5 percent, three times the rate for all workers.(6, p. 7) Contributing to the problem of youth unemployment are increasing numbers of young people participating in the job market, changes in our nation's economic base, and inadequate educational attainment, especially among minority youth. The inability of disadvantaged youth to find gainful employment, combined with forecasted shortages of adequately trained workers, may be a threat to the economic security of our nation.

From 1960 to 1979, the labor force grew from 11.5 million to 25.4 million, an increase of 120 percent. Young workers accounted for nearly one-third of this overall rise.(8, p. 20) Today's youth enter the labor market earlier, and most combine school with work. Many are from single-parent families and a significant number are single parents themselves. Minority youth, however, participates less in the labor force than white youth. In 1986 approximately 57 percent of black and 66 percent of Hispanic youths were in the workforce, compared with 71 percent for whites.(8, p. 21)

Changes in the nation's economy have also contributed to joblessness among youth. As the least experienced members of the workforce, youth are the most susceptible to economic booms and busts. The transformation of our economy from an industrial to a post-industrial base has resulted in job requirements beyond the reach of most youth. While many new jobs have been created in the service sector, almost three-fifths of the new jobs generated in this decade paid under half the median income of year-round, full-time employees.(7, p. 5)

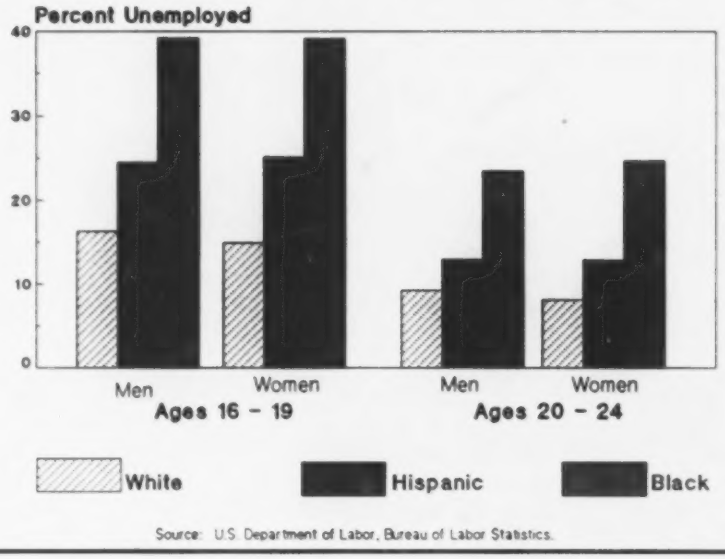
Failure to complete a high school education also creates problems of joblessness among youth. Educational attainment is more important than ever in the new information-based economy. Young people, who by age 18 have the weakest basic skills, are five times more likely to have dropped out of school and be jobless than their peers with above-average skills.(6, p. 4) For many youths, high school education, even when completed, is inadequate. According to the National Assessment of Educational Progress, many young adults graduate from high school with minimal literacy skills and a lack of ability to think critically.

Minority youth have suffered the most from these national demographic and economic changes. While millions of blue-collar jobs have disappeared from our cities, minority youth in particular face insufficient education and training for the new information-processing industries. Black high school dropouts, for example, experienced a 47.1 percent unemployment rate in 1986, while white high school dropouts experienced a 20.7 percent rate. Blacks who did complete high school also fared poorly in the job market, with a 27 percent unemployment rate, compared with a 9 percent rate for whites.(8, p. 22) Black youth of both sexes, between the ages of 16 and 19 years, have an unemployment rate of nearly 40 percent, more than twice the rate for white youth of the same age.

Both the federal and state governments have made efforts to ease the road to self-sufficiency among youth. In the past year, Congress has become increasingly interested in the idea of a national youth service corps. Existing federal programs leave states considerable discretion to use federal funds for youth employment and job training. However, federal funds have been severely cut in

recent years. While state financial commitments to youth employment vary, state-funded and -coordinated initiatives have attempted to fill the federal funding gap.

Figure 6.
Unemployment Rates of Young Adults: 1986



Source: U.S. Department of Labor, Bureau of Labor Statistics.

Federal Policy

Federal attention to youth employment began with the CCC, created in 1933. The corps provided jobs restoring and maintaining our nation's forests, parks, and public spaces.

Recent federal youth programs have included the Manpower Development and Training Act of the Kennedy administration, the Employment Opportunity Act of the Johnson administration, and the Comprehensive Employment and Training Act (CETA) for the Summer Youth Employment program, and the Job Corps programs under President Nixon. President Reagan replaced CETA with JTPA, which set up a network of PICs and gave state governments more discretion in program administration than what was available under CETA. Federal law requires that 40 percent of JTPA funds be spent on people younger than age 22. Funding for youth employment through the JTPA was severely cut under President Reagan, reducing the number of enrollees from 740,000 in 1985 to 375,000 in 1988.

JTPA's record has included some significant accomplishments. Private sector involvement has grown and has generated greater confidence in federal employment and training efforts. Local school-to-work programs have had success in tapping JTPA funds for programs that increase the employability of youth. However, JTPA's biggest flaw is an inability to target the needs of disadvantaged youth. Many JTPA programs refuse to accept individuals into training unless they are able to read at a high school level, a requirement that precludes participation by most high school dropouts. In addition, JTPA programs seldom provide support services, such as child care for young mothers.

The future of federal youth employment policy may include a new G.I. Bill expanded to include civilians as well as military service personnel. The idea of a "Citizens Corps" has been proposed and is widely supported by the American public. National civilian service would provide

high school graduates with the option of military or civilian positions for two years, with participants earning subsistence wages and vouchers worth substantial federal aid for college, vocational or job training, or housing. Under the Citizens Corps' concept, national service vouchers would replace existing federal grants and loans as the primary source of federal aid to students. Federal youth employment policy may soon complete a cycle back to the idea of the CCC of the Depression era.

State Policy

Many states and communities are trying to fill gaps left by federal budget cuts. Thirty-four youth conservation corps or community service programs have been established at state or local levels, although most state programs remain relatively small. In addition, some states such as Minnesota have launched broader job creation programs that, while not targeted at youth alone, offer employment to substantial numbers of teenagers.

State efforts to date include service and conservation corps, school-to-work transition programs, initiatives designed to improve coordination among youth service agencies, and vocational skills or apprenticeship programs. Sample state initiatives include:

- New York's School to Employment Program (STEP) gathers disadvantaged students after school for counseling to prevent dropping out, for tutoring, and for placement in part-time jobs that provide work experience and extra income. Counselors also work with students to develop career plans. New York also has created a successful Youth Work Skills Training Program that targets educationally disadvantaged youth and provides remedial education and vocational training together with other support services.

- Michigan's Tuition Incentive Program (TIP) provides high school students incentives for staying in school until graduation. Among the TIP incentives are paid employment opportunities for needy youths. Another Michigan program offers high school students the incentive of a voucher for two years' education at a community college, if they are from poor families and graduate from high school before age 20.

- The California Conservation Corps is among the oldest state-run youth employment programs in the nation. The corps operates a training academy as well as a chain of 49 residential and nonresidential centers throughout the state. Participants, many of whom are poor and of minority backgrounds, are paid at the minimum wage to maintain public property and assist with flood and fire relief.

- Massachusetts has recently taken a different approach to improvements in youth employment. The Commonwealth Futures program promotes institutional change by coordinating existing programs, institutions, and agencies that serve at-risk youth. The program's objective is to knock down institutional barriers that prevent young people from finishing school and pursuing vocational training. Local officials have seen decreasing dropout rates and social service youth caseloads as a result of the reorganization.

- North Carolina schools are operating a Job Readiness Training program developed by a private research and demonstration organization, MDC Inc. The program offers disadvantaged youth a mixture of motivational and practical exercises designed to help them learn about the world of work.

Key Points

In examining the policy implications of a successful transition from school to work, and in providing adequate employment for youth, the following points need consideration:

- Successful model programs for youth employment have existed in the past and continue to exist in the states and localities. The Job Corps created by CETA and the Conservation Corps existing in the states are effective ways to employ youth, provide public service, and prepare youth for their futures.

- The employment base of our nation has changed. Manufacturing employment for males under age 20 fell from 44 percent in 1973 to 22 percent in 1986.

- The minimum wage has not increased along with average wages in this country. The minimum wage is currently less than 40 percent of the average U.S. wage. This is the first time since 1938 that it has fallen below 50 percent of the average wage.

- At every level of education, black youth experience higher unemployment than white youth. Their labor market disadvantages include lower levels of educational attainment, often in inferior schools, lack of familial contacts with mainstream job opportunities, and fewer "good" job opportunities near their homes. Hispanic youth face many of the same problems, but their jobless rates are much lower than those of blacks.

- The percentage of minority youth will increase during the coming decade. In 1988, 17.8 percent of youth from age 18 to 24 were minorities. In the year 2000, 20.7 percent will be minorities. Since recent trends indicate that minority youth experience more trouble in the job market, youth employment programs will be challenged to meet increasing demands in the future.

- Joblessness varies inversely and sharply with educational attainment. Dropouts carry an extra set of negative labels and gravitate to the bottom of employers' hiring lists.

- Recent job participation rates among male and female youth show a steady increase in participation among females and a decrease among males. This is primarily due to job creation in the information and service industries where women are hired more often than men. Projections are that this trend will continue and will result in a larger share of young women compared with young men comprising the labor force.

- Employability is a function of many factors, including basic reading, writing, and math skills, general competency, work maturity, and occupational skills. Youth employment programs must address all these factors to be successful.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to increase employment and training opportunities for disadvantaged youth:

- Increase legislative oversight of existing youth employment service programs. The Massachusetts Commonwealth Futures program has shown that coordination of youth services can produce concrete results.

- o **Establish incentive programs, like that of Michigan, to encourage disadvantaged youth to complete their high school educations or GED accomplishment and go on to college or vocational training.**

- o **Provide remedial or alternative education programs for youth that have dropped out of school.**

- o **Provide supportive services, such as child care, to enable young mothers to complete their education and participate in vocational training programs.**

- o **Create a Conservation Corps that provides youth with job opportunities and training and the state with a workforce for public works maintenance.**

- o Encourage, through legislative oversight, use of federal funds for private youth employment and training programs, if the programs have proven track records in the state. The North Carolina Job Readiness Training program is an excellent example of a successful private effort paid for by federal funds.

- o Create school-to-work transition programs in the schools for noncollege-bound youth. Initiatives that provide high school seniors with employment preparation, job placement assistance, counseling, and peer support have increased the employment rates of participants by nearly one-fourth and have yielded the greatest gains among disadvantaged youths.

- o Incorporate GED programs in state correction facilities.

- o Explore opportunities to involve business in public/private partnership to create more jobs for disadvantaged youth.

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PARENT EDUCATION FOR PARENTS WITH CHILDREN FROM BIRTH TO THREE

Commentary

In 1988 there were 2.2 million reports of child abuse and neglect.(3, p. 79) In 1987-88, the national high school dropout rate was 28.9 percent.(2) Early intervention and parent education can significantly decrease the occurrence of both child abuse and neglect and failure in school. These programs provide family support and strengthen both parenting skills and children's skill development. Parent education improves parent/child relationships and in turn improves the child's school performance and social adjustment.

Parenting programs are designed to reduce incidence of abuse by educating and supporting families in the parenting process. Child abuse is less likely to occur in families that have strong and supporting social networks. Support once provided by stable neighborhoods or close-knit families, however, may not be available in contemporary America. Since parenting skills are not innate, programs are needed to inform parents about normal child development and provide parents with reasonable expectations of child behavior. Often, the parents that are most at risk of abusing and neglecting their children are teenage parents or low-income or highly stressed families that are isolated either geographically or socially.

As the child's first teacher, parents need to be aware that spending more time playing, talking, and reading to their children will enhance their mental and emotional development. Strong and affectionate relationships developed early between parents and children appear to produce better school performance.(16, p. 9) In addition, children whose parents have been involved in family support programs have fewer special education needs.(16, p. 11) Between birth and three years old, a child begins thinking logically, building positive self-esteem, and developing friendships. If children fail to gain such traits by age three, negative tendencies such as irrational thinking and antisocial or destructive behavior can develop. To prevent these negative tendencies, early childhood programs that involve the parents should begin as early as possible in the child's life and continue until the child starts school.

Parent education programs vary in their scope of services. Some focus on at-risk families and children, while others offer services to all families. Most programs offer services to parents prior to birth and continue through the child's third year. Other programs continue to work with children until five or eight years of age. The most effective programs, particularly for low-income and highly stressed families, are comprehensive and address not only educational needs, but health, social, and nutritional needs of the child as he or she grows up.(16, p. 14) Although qualifications vary, the programs are usually staffed with licensed or paraprofessional personnel that are trained in parent education and early childhood development.

Federal Policy

One of the most important federal investments in parent education has been the creation of Parent-Child Centers (PCC) administered through Head Start. The program, which targets low-income families, has been in effect since 1967. The PCCs provide comprehensive services to improve developmental progress in children from birth to age three. The programs acknowledge the importance of the parents' role in the child's development by seeking to strengthen parental skills and the understanding of parenting. The PCCs respond to the needs of the community in which they are

located. As a result, the programs vary in terms of the number of days per week and hours per day that they operate, the services provided, and program designs. Located in 28 states, 36 centers serve approximately 4,500 children and their families.(5, p. 4)

The Comprehensive Child Development Act, passed in 1988, is based on the success of PCCs. This legislation appropriates $25 million for five years to establish 10 to 25 Child Development Centers across the country for low-income children from birth to compulsory school age.

The centers are to provide or coordinate education in infant and child development, nutrition, and parenting. In addition, they must make available infant and child health services, early childhood development programs, and child care.(4)

State Policy

Currently, three states offer statewide parent education programs. Minnesota, Missouri, and Maryland provide parent education programs that serve a variety of families and communities. Both Minnesota and Missouri have programs that are available to any interested family. Maryland's program is geared specifically for at-risk teenage parents and their children.

In 1974 Minnesota passed legislation establishing the Early Childhood Family Education (ECFE) Program. Initially, the state funded pilot projects in six school districts.(12, p. 13) In 1984 legislation was passed that allowed for statewide implementation.(12, p. 13) By 1988, 290 of Minnesota's 435 districts had implemented ECFE programs providing services to 135,000 individuals. (15, p. 3) All parents with children from birth to age six are eligible for ECFE. Low-income and very stressed families are actively recruited. ECFE programs provide information on child development and parenting skills, health and developmental screening, community resources, and educational materials for use at home.(6) The programs usually consist of a one and one-half to two-hour session per week. During this session, time is allotted for parent/child interaction, preschool classes for the children, and support groups for the parents. Each part of the session is supervised by licensed professionals. About $160 was spent per child and $160 per parent in 1987-88. In 1988 the funding for the ECFE Program totaled $18.2 million--a combination of state and local levies.(15, p. 4)

Missouri's Parents as Teachers (PAT) Program began in 1981 as a pilot project in four school districts. It is designed to help prevent a child's failure in school and promote the well-being of the family.(12, p. 17) The program is available on a voluntary basis to any family who wants it. However, at-risk families, including those living in homeless shelters who otherwise would not participate in the program, are actively recruited. The main goal of PAT is to maximize a child's overall development during the first three years of life and to demonstrate that, by supporting parents during this period, children are able to thrive in preparation for school.(12, p. 18) The staff, called parent educators, receive certification from the state and also are required to participate in regularly scheduled in-service training. In 1984 legislation was passed requiring all school districts to offer PAT for families with children under age five.(12, p. 17) The program also provides for periodic developmental screening of the child to make sure she or he is progressing normally. Currently, the amount of money allocated through the Department of Education budget for the program averages $170 per family for a minimum of five contacts (three must be personal) and $20 per child for developmental screening.(18) In 1988 more than 50,000 families were served throughout the state.(11, p. 36) The funding for the 1988-89 school year was $11.4 million.(12, p. 18)

In 1985 Maryland's Department of Human Resources established four community-based drop-in centers to provide support to adolescent parents and their children from birth to three years old.(10) Currently, eight Family Support Centers are operating in diverse settings throughout the state, and three more are in the process of being funded.(12, p. 9) All of the centers operate in areas that have a high concentration of at-risk children, as measured by high numbers of births to mothers who are single teenagers, are on medical assistance, or have less than a tenth-grade education. The

centers help teenage parents develop parenting skills and raise their self-esteem to enable them to become better parents and assure the healthy growth and development of their children. The programs provide a variety of support services including: 1) education on the prevention of unwanted pregnancies, 2) help for young parents to learn parenting skills, 3) identification of health care services to ensure the healthy growth and development of children, and 4) educational opportunities for the teenage parent, including obtaining a GED.(12, p. 10) With a budget of approximately $1.4 million in 1988, the program served 2,500 individuals.(14)

Unlike the statewide programs in Minnesota, Missouri, and Maryland, some states have state-funded pilot programs, and others have programs run by private, nonprofit organizations. For example, Oregon's Together for Children (TFC) Program began in the fall of 1988 with three pilot programs. The intent of Oregon's program is similar in scope to the Missouri and Minnesota programs, although it specifically targets parents with children between the ages of zero and eight years who are assessed as at risk of failing in school. Target populations include migrant families, teen parents, parents of infants, and low-income parents. With three different models in three communities, the program is funded by the Department of Education budget. Each community independently decides which aspects of the program to offer, although each includes teenage parent services, home visits, classes, and parent support groups. Nearly 6,000 parents will be served in the 1988-89 year, with approximately 376 families receiving intensive services.(8)

Table 1.
Parent Education Programs in Five States

State	Eligibility	Number Served	Budget
Illinois Family Focus	All parents with children 0-3 years old	5,000+ individuals	$2 million+ (FY 88-89)
Maryland Family Support Centers	Teenage parents with children 0-3 years old	2,500 individuals (estimate for 1988)	$1.4 million (estimate for FY 88 of state funds)
Minnesota Early Childhood Family Education (ECFE)	All parents with children 0-6 years old	135,000 individuals (1988)	$18.2 million (FY 1988)
Missouri Parents as Teachers (PAT)	All parents with children 0-3 years old	50,000+ families	$11.4 million
Oregon Together for Children	At-risk families with children 0-8 years old	6,000 families with 376 families receiving intensive services	$266,000+ (FY 1988)

Washington's Parents as a First Teacher Program is operated as a voluntary grant-based program by the superintendent of Public Instruction. Its purpose is to provide resource materials on home-learning activities, private and group educational guidance, and experiences for parents and children to encourage parent confidence and a positive home environment. This voluntary enrichment program may be offered only as funds are made available for this purpose. The program is for parents with children up to the age of three. Every two years, the superintendent of Public Instruction must report to the legislature by January 15 on the program and make information on it available through the Educational Clearinghouse.

The superintendent of Public Instruction, Department of Social and Health Services, and Department of Community Development will coordinate the Parents as a First Teacher, Early

Childhood Assistance, and Family Independence programs. The agencies must report to the legislature by January 15, 1990, on the implementation of the coordination of these programs.

In 1986 Arkansas implemented the Home Instruction Program for Preschool Youngsters (HIPPY), which pays community-based paraprofessionals for in-home preschool instruction. Modeled after an Israeli program, HIPPY asks mothers of four- and five-year-olds to work through a package of basic learning materials with their youngsters for 15 minutes, five days each week, 20 weeks each year, for two years. A paraprofessional--often a mother who has completed the course--makes periodic visits to monitor the progress of both mother and child. Between its inception and June 1988, the program served over 1,000 families, many in poor, rural communities. In one county, children in the program made 14 months' progress in eight months. The program helps educate preschool children and boost mothers' confidence in their abilities as educators.

Kentucky allocated $1.8 million for the 1988-89 fiscal years to continue the state's experimental Parent and Child Education (PACE) Program. This service, located in 12 low-income school districts, is part of a joint adult education/early childhood education development program in which parents work toward their GEDs, while their children participate in preschool activities. Parents are also given parenting classes. In the first two years of operation, PACE served 700 parents and children at a cost of approximately $800 each. Seventy percent of the adults received a GED or added two years to their schooling. The children raised their developmental levels considerably.(12, p. 5)

Illinois has a strong parent support program based in the Chicago metropolitan area. The program, Family Focus, serves all parents with children from birth to three years through a center-based program. More than 5,000(13) people are served by a paraprofessional staff. The seven Family Focus centers have different programs depending on the needs of the surrounding community.(7, p. 3) Despite variations, all centers have scheduled support groups as well as drop-in services. As a private, nonprofit organization, the program had an annual budget of more than $2 million(13) for the 1988-89 fiscal year. It receives about one-half of its money from state agencies and public and private partnerships.(1, p. 9)

In 1988 Illinois passed legislation that requires the State Board of Education to implement pilot parental training programs for parents with children from birth to three years old. Although no appropriation has been authorized, it is assumed that the pilots will be based on the Family Focus model when funds become available.(4)

Key Points

In examining the issue of parent education for parents with children from birth to three, the following points should be considered when developing public policy:

- Parent education can help prevent child abuse and neglect and school failure.
- Parents are a child's first teacher, but parenting skills are not innate.
- Parental support is often unavailable in contemporary America. Parents that need the most support may be geographically or socially isolated and often have low incomes.
- Effective programs address education, health, nutrition, and social needs of the child.
- Programs can provide services to both universal and at-risk populations.

- Many states provide parenting programs in a limited geographical area. Some states, notably Maryland, Minnesota, Missouri, and Oregon, have implemented statewide programs.

- For the most part, the implementation of statewide programs seems to be school based.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to implement parent education programs:

- Assess the need for parental education in the state and available resources for parental support.

- Design programs specifically to meet the needs of the targeted population.

- Conduct special outreach efforts for the parents of infants and toddlers that are most at risk, including low-income and geographically or socially isolated families.

- Require trained staff to run quality parent education and early childhood education programs.

- Work toward the development of universally available services on a sliding fee scale, with comprehensive services available to at-risk populations. Comprehensive services include: health and nutrition education for parents regarding infants and toddlers; attention to child development and educational needs of children; and the social interaction needs of children and families in any parental education program.

- Evaluate existing programs to identify duplication and facilitate the creation of an efficient service delivery system.

- Encourage companies with more than 50 employees to provide parent education services.

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EARLY CHILDHOOD EDUCATION

Commentary

Early childhood education programs can change the lives of all children, especially economically disadvantaged children. Twenty percent of preschool children live in poverty. Poor children are often physically and emotionally deprived and are at risk of social and academic failure. Without the skills generally associated with success in school, poor children often fail and drop out. Poverty and academic failure can contribute to later social dysfunction, including teenage pregnancy, juvenile delinquency, and involvement in crime. Poverty too frequently translates into a lifetime of dependency. Two out of five children from the poorest one-fifth of families remain in the poorest one-fifth as young adults: seven out of 10 remain in the poorest two-fifths of the population.(7, p. 5)

Mounting evidence suggests that low-income children who participate in high-quality early childhood education programs are more likely than other low-income children to succeed academically and socially. While in primary school, these children are more motivated to learn and possess greater self-confidence. These same children are less likely to be placed in special education classes, to be classified as mentally retarded, and to be held back. They are also more likely to complete high school. Low-income children who attend early childhood education programs are less likely to receive public assistance as adults and are more likely to be employed or in post-secondary education programs at age 19. As teenagers, they are also less likely to become pregnant and show lower detention and arrest rates.(3, p. 38)

Program quality determines whether these benefits can be realized. The study most often cited of both short- and long-term benefits of early childhood education is the Perry Preschool Study, which began in 1962 and is still continuing. The study consisted of a sample of 123 three- and four-year-old black children from low-income families. Approximately half of the children in the study attended a well-designed, quality early childhood education program and half did not. The program was center based, required parental involvement and low staff/child ratios, and included a comprehensive system of services, including health and nutrition. The curriculum stressed intellectual and social development. Operating on a half-day basis, the program ran five days a week, for seven months out of the year. Most of the children in the study attended the Perry Preschool for two years. Teachers were highly trained in child development and conducted home visits with the mothers. Program costs, in 1981 dollars, were estimated at $4,818 per child for one year and $9,708 per child for two years.(1, p. 334-S)

Cost-benefit analyses suggest that for every dollar spent on early childhood education for economically disadvantaged children, the state can save $4.75 over the long term. Reduced spending on special education, welfare, and criminal justice costs for these "preschool graduates" is accompanied by increased tax revenues resulting from their expected earnings. These cost-benefit analyses suggest that the state can experience a 595 percent benefit from the initial cost of funding one year of early childhood education or 300 percent over the cost of two years. However, standards of quality must be assured to realize similar cost benefits.(3, p. 39)

The increased number of economically disadvantaged children and the mounting evidence of the benefits of quality preschool programs have convinced many state legislatures to implement such programs. In addition, the growth in the number of preschool children and mothers in the labor market has prompted state policymakers to implement programs for young children.

Federal Policy

Federal programs in the preschool arena include Head Start, Chapter One of the Education Consolidation and Improvement Act (ECIA), and the Family Support Act of 1988.

- *Head Start*. Since its inception in 1965, the Head Start program has become the major federal service for low-income preschool children and their families. Head Start targets low-income children ages three to five. Directed by the Administration for Children, Youth, and Families, 10 regional offices throughout the country disperse money to Head Start grantees in local communities. Currently, 1,291 Head Start programs serve more than 450,000 children with an average annual cost per child of $2,592.(5, p. 1) Head Start has a comprehensive approach to serving families. Programs include four major components: education, health, social services, and parental involvement. However, due to budgetary limitations, the Head Start Bureau estimates that only between 16 to 20 percent of eligible children are being served.

- *Chapter One*. Chapter One of the ECIA provides financial assistance to local school districts for compensatory education services for disadvantaged children. These funds are targeted to low-income schools for students with low achievement. Approximately 19 percent of all school districts using Chapter One funds provide prekindergarten programs.

- *Family Support Act*. States are required to implement welfare reform programs that include education and training programs for eligible AFDC recipients. States must guarantee child care for program participants during training and education and up to 12 months after they lose benefits due to employment. Funds may be available for grants to 10 states to demonstrate the effect of early childhood development programs in enhancing communication skills for AFDC children and families. As required under the act, child care provided through state welfare reform programs must be coordinated with early childhood development and education programs including Head Start, Chapter One, and school and nonprofit child care programs.

State Policy

Early childhood education programs are different from traditional primary and secondary educational models. Their unique characteristics relate to the role of parents, specific curriculum approaches, and coordination of services to young children. In addition, states fund these programs in a variety of ways.

State Dollars for Early Childhood Education. At least 29 states currently provide money to preschool programs, primarily for half-day programs for three- and four-year-olds. (See Table 2). States spent almost $225.6 million for preschool programs in 1988, up 27 percent from the previous year. The funds were used to serve 319,951 children and included $16.8 million in state Head Start supplements.(3, p. 40)

States use various methods of dispersing early childhood education funds. In some cases, preschool programs receive state money as part of a state school finance formula and operate in the public schools. The most common method of funding early childhood education, however, is through grants or contracts awarded by a state administrative agency. In all cases, except in Iowa and Washington, this agency is the Department of Education. Fourteen states award grants or contracts for early childhood education programs, most often through a competitive process. In these states, the public schools, child care centers, Head Start programs, or other agencies are eligible as recipients. Eight states appropriate funds to expand Head Start.(4, p. 2)

Table 2.
Status of State-Funded Preschool Initiatives

State[1]	Existing[2]	Planning Stage	Proposed or No Funding
Alaska	Alaska*	Indiana	Alabama
California	Connecticut	Kentucky	Arizona
Colorado	Hawaii	New Hampshire	Arkansas
Delaware	Maine*	North Carolina	Georgia
Florida	Massachusetts*	Rhode Island	Idaho
Illinois	Minnesota*	Virginia	Kansas
Iowa	Rhode Island		Mississippi
Kentucky	Washington*		Montana
Louisiana			Nevada
Maine			Nebraska
Maryland			New Mexico
Massachusetts			North Dakota
Michigan			South Dakota
New Jersey			Tennessee
New York			Utah
Ohio			Wyoming
Oklahoma			
Oregon			
Pennsylvania			
South Carolina			
Texas			
Vermont			
Washington			
West Virginia			
Wisconsin			
25 states	**8 states**	**6 states**	**16 states**

1. General enactments
2. Head Start-only enactments
* States that have other state-funded preschool programs

Source: *Child Care and Early Childhood Education Policy: A Legislator's Guide*, National Conference of State Legislatures, March 1989.

Several states require that state money be matched with local or federal money or in-kind services. New York requires an 11 percent local match. Difficulties arise when poor districts, those most often in need of such services, are unable to finance local programs. New Jersey and Texas require matches based on the economic conditions of the school districts.

Children Served. None of the states offers universal early childhood education for all preschool children, and a majority of states target their programs to "at-risk" four-year-olds. Definitions of *at-risk* differ among the states but generally include low-income, economically disadvantaged children who are deficient in English and have academic difficulties.

Twelve states target low-income children for early childhood education programs. California children from families whose income is up to 60 percent of the state's median income are eligible for

such programs. Oregon targets children who would be eligible for Head Start but who are not currently being served. Massachusetts designated 75 percent of its grant money for low-income areas; 90 percent of the children in New York's early childhood education programs must demonstrate economic need. Texas targets both economically disadvantaged and English-deficient children. Louisiana, South Carolina, and West Virginia target children who are likely to fail readiness tests for public schools.(4, p. 4)

Role of Parents. California, Colorado, Delaware, Illinois, Iowa, Kentucky, Louisiana, Massachusetts, New York, Oklahoma, and Washington include parental involvement as part of their programs. Although the specifics of such involvement may be determined locally, it is significant that parents are considered an integral part of these states' early childhood education policies.(2, p. 7)

Washington has established an innovative program called Project Even Start for parents whose basic academic skills are below eighth-grade level. These adult literacy programs will be available for the parents of children eligible for Head Start, the Early Childhood Education Program, and elementary school programs serving students below average in the basic skills of reading, language arts, and mathematics. In addition to instruction in basic skills, eligible parents will receive support services, including transportation and child care. The superintendent of Public Instruction will work cooperatively with adult literacy programs in the public schools, vocational technical institutes, community-based programs, and community colleges to implement this program.

Curriculum Approaches. Early childhood education is not first grade for four-year-olds. California, Florida, Illinois, Iowa, Louisiana, Maine, Massachusetts, New York, and Ohio specify that their early childhood education programs reflect "developmentally appropriate" curricula. Essentially, each state's curriculum is based on normal developmental characteristics of preschool-age children so that learning occurs within a context corresponding to the child's abilities and maturity level. Theoretically, this provides preschool-age children with a learning environment that is consistent with their needs. It further ensures that their experiences are not based merely on curriculum models used with older children in primary grades.(4, p. 4)

Staff-child ratios are important in the overall early childhood education experience and in the optimum implementation of curricula. Having sufficient numbers of adults to supervise children and to give them needed attention is critical to the success of a program. The recommended ratio of staff to children falls as children get older. The federal standards promulgated between 1968 to 1981 were one adult to three infants up to age one, one adult to four children from ages one to three years, and one adult to eight children from ages three to five years.(6, p. 2) David Weikart of the High/Scope Foundation recommends "at least two adults for each group of 16 to 20 children," in a successful child development program.(8, p. 19)

Coordination of Services. Coordinating services with preschool programs varies among the states. Early childhood education programs that are coordinated with area child care services can meet both the developmental needs of the child and the day care needs of the parents. Massachusetts stresses coordination of early childhood education programs with services of special needs children and other community services, including daycare. Vermont emphasizes coordination between school districts and local daycare services in the implementation of its early childhood education programs, and Washington encourages connections with Head Start and other supportive services agencies.

Although not necessarily identifying specific methods of interagency cooperation or coordination, California, Iowa, Maine, New York, Oregon, South Carolina, and Washington approach early childhood education from a comprehensive perspective similar to that of federal Head Start programs. Early childhood education programs in these states include nutrition, health care, and social and intellectual development components.(4, p. 4)

Key Points

In examining the problem of early childhood education, the following points should be considered when developing public policy:

- The 20 percent of preschool children who live below the poverty level are at risk of social and academic failure that can lead to social dysfunction, including teenage pregnancy, juvenile delinquency, and involvement in crime.

- Short- and long-term academic and social benefits to disadvantaged preschool children enrolled in quality early childhood education programs include a reduced need for special education; lower dropout, delinquency, and adolescent pregnancy rates; and less need for welfare in adulthood.

- Every dollar spent on quality early childhood education programs for economically disadvantaged children can save $4.75 for the state over the long term.

- The Family Support Act of 1988 requires states to implement job training and education programs for qualified AFDC recipients. States must guarantee child care up to 12 months after program participants lose benefits due to employment. Child care provided through state welfare reform programs must be coordinated with other early childhood care and education programs in the state.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to intervene in the lives of young children:

- Fund pilot projects to test different models for early childhood education programs, establish regulations and program guidelines to ensure that programs are properly tested, and allow programs sufficient time to test and refine local strategies.

- Develop early childhood education programs incorporating developmentally appropriate curricula and culturally relevant instruction for young children.

- Review state policies related to assessment and testing of young children to determine the local impact of tests; ensure that test instruments, training for test administrators, and test administration are consistent with the test purpose; and explore alternatives to standardized tests.

- Encourage parental involvement by examining the communication between parents and schools, reviewing family support and education programs, and providing materials and training for school staff and administrators to assist in increasing parental involvement.

- Assess policies related to training and certification of early childhood education teachers to ensure that teachers have specialized training and experience in working with young children; opportunities for career development; training in child development, developmentally appropriate curriculum and assessment, culturally responsive practices, and good communication skills; extensive and varied field experience; and continual professional development.

- o **Promote interagency collaboration in planning, standard-setting, and program development among the Departments of Education and Human Services and other agencies sponsoring programs for young children and their families.**

- o **Provide comprehensive services to at-risk children, including education, nutrition, and health services.**

- o **Assure quality programming by providing salaries that attract and retain qualified staff and maintaining low child/staff ratios and class size.**

- o **Provide quality early childhood education services to children of parents in state education and job training programs and to children of parents who quality for transitional child care services under the 1988 Family Support Act.**

- o Coordinate early childhood education programs with full-day daycare services while making use of existing programs and resources within the Department of Education, Department of Human Resources, Head Start, and public and private child care providers.

- o Require rigorous scientific evaluation of early childhood education programs to ensure accountability.

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FAMILIES AND THE SCHOOL SYSTEM

Commentary

Parental and family involvement in the education of children has become an important part of the recent debate about future school reform. Research shows that children do better in school and schools improve when parents are involved.

The National Committee for Citizens in Education recently published *The Evidence Continues to Grow*, a description of 49 studies on parental involvement in schools. All of the studies found positive results from parental participation in education. Programs with parental involvement produced test scores higher than those in identical programs that did not involve parents. The benefits included higher grades and test scores, long-term academic achievement, positive attitudes and behavior, more successful school programs, and more effective schools.(3, p. 60)

According to a National School Volunteer Program survey, nearly 1.3 million parents and more than four million people are currently taking part in school volunteer programs (1987-88 school year). Volunteering in schools, however, is just one form of parental involvement. Family education with emphasis on developing parenting skills and other home activities, such as supervising homework and reading aloud, are other ways that parents can be involved in their children's education. These types of involvement do not require participation during "normal" work hours.

Over 20 major national education organizations have joined the National Community Education Association in organizing the National Coalition for Parent Involvement in Education (NCPIE). NCPIE is dedicated to developing school/family partnerships and affecting national policy by encouraging state leaders to develop policies that encourage family involvement in schools.(2)

Federal Policy

A number of federal education programs have encouraged parents to be involved in the education of their children. One notable example, the Title I Compensatory Education Act, requires schools with Title I programs to work with parent groups. Title I was changed to Chapter One by the Education Consolidation and Improvement Act of 1981. Chapter One was amended by the Hawkins-Stafford Amendment of 1988, which required more accountability for student achievement and emphasized greater parental involvement in providing education programs to disadvantaged children.

In 1988 NCPIE and other groups lobbied congress to strengthen Chapter One by including formal parental involvement programs, a set of recommended activities, and parenting education, including parent-effectiveness training.

Two other 1988 federal education achievements were Project Even Start and Family-School Partnership. Project Even Start is discussed in the section entitled "Early Childhood Education." Family-School Partnership authorizes demonstration grants to encourage local school districts to increase parental involvement.(5, p. 26)

State Policy

State legislatures have encouraged parental participation through several policies. Most notable of these is community education legislation. Since 1974, 27 states have enacted some form of statute supporting community education.

Recently, some policymakers have argued that providing school "choice" adds to parental involvement. Minnesota and Iowa have passed new statutes on school choice. The following examples are representative of recently passed state laws.(4, p. 4)

Minnesota's Chapter 718 expands schools' community services roles in a variety of ways. Programs created by this law include: 1) free public secondary education for up to two years for adults in the district, who are over age 21 and do not yet have a high school diploma; 2) prekindergarten programs for young children with developmental delay; and 3) community service programs to promote citizenship, expand students' learning opportunities, and address community needs through extended-day programs for students in grades K-6.(4, p. 4)

In Iowa S.F. 323 permits parents to enroll their children in schools outside the home district. The bill includes a provision requiring parents to present evidence that the new school offers an academic program not offered in the original district. Another provision is that students must remain in the new school for at least four years, or until high school graduation. State per-pupil aid transfers to the new district, but school property taxes do not. Parents are not charged any additional costs but are required to provide transportation for their children to the new district. They must also inform the home district and the State Board of Education, by November 11 of the preceding year, of their intention to transfer a student. Lastly, schools must accept students unless there is inadequate space.(4, p. 4)

Georgia's 1988 legislature created community education grants with the passage of H.B. 1488. This bill authorized the Department of Community Affairs to extend grants to boards of education for the creation, administration, operation, and coordination of community education programs and activities.(4, p. 4)

State legislators in Rhode Island passed H.B. 7923 to include community members in a special school committee created to select educational programs for extra state funding. Funds have been allocated for programs in special education, vocational education, adult education, and limited English-speaking education. The school committees will select programs best suited for their community's needs.(4, p. 4)

In 1988 the Colorado General Assembly passed a law creating a new school finance formula. In addition to the financial specifications, H.B. 1341 directs the State Board of Education to fulfill certain "educational achievement" provisions. These include adopting goals for the improvement of Colorado's educational system, selecting educational policy areas for new programs, and determining the best uses of technology within the system. The school districts also have been called on to improve achievement. Committees of parents, education personnel, and community members must be formed to develop ways of measuring the effectiveness of schools and to create plans for improvement.

South Carolina's School Improvement Councils, first called "advisory councils," began in 1977 and required each school board to establish such a council at each school. The councils had to include at least two parents, as well as other representatives of the community. The main purposes of a council included the preparation of an annual school report, assistance to the principal, and the performance of any duties assigned by the local board. The passage of the Education Improvement Act (EIA) in 1984 renamed the panels "School Improvement Councils" and refocused the mission on working to improve schools rather than on the original advisory capacity. Funding was provided for

the training of councils, and a school incentive fund was established to reward and recognize schools for exceptional performance. The councils have helped improve school/community relations, increase parental involvement, and provide more information to parents.(5, p. 24)

Florida has passed legislation to promote volunteerism and parent-effectiveness training in the school districts with a matching grant program. Any district submitting a plan receives $2,000. Additional money is awarded based on the number of elementary and secondary schools offering programs such as career education, adult and community education, school volunteers, vocational training programs, and business partnerships. State records show 135,551 volunteers have provided more than 5.5 million hours of service. At $10 per hour, state schools received more than $55.7 million for the 1987 effort alone.(5, p. 22)

Key Points

When examining issues concerning family involvement in public schools, state legislators should consider the following points in developing public policy:

- Parents can be involved as volunteers in classrooms, as accountability committee members, as mentors to their children, or simply as parents who are concerned about homework, parent-teacher conferences, and student attendance.

- A definition of family should include single parents, noncustodial parents, those with both parents working outside the home, blended families, homeless families, and those with teenage parents.

- Community education programs involve the extended school family in school activities. School/Business Partnerships, Adopt-a-School programs, Make-a-Wish programs, and similar community involvement plans assist with the extended school family participation.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to implement better interaction between parents and the school system in educating children:

- Design policies that encourage parents, education personnel, and the community to work together.

- Consider providing exemptions from regulations that conflict with parental involvement.

- Promote collaboration between agencies at state and local levels to provide more comprehensive programs and services for schools and families and to avoid duplicating services.

- Provide funding for training programs necessary for the involvement of communities and families.

- Include parents on state accountability committees.

- Stress parental/family involvement programs in those higher education institutions that teach educators.

- o Fund a state office of parental involvement to assist local efforts.
- o Provide support for community education programs.

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DROP-OUT PREVENTION

Commentary

Students at risk of dropping out of school represent one of the major crises facing this country. While concerns about drop-outs have long been expressed, the most compelling arguments for preventing school drop-outs are linked to economic development, civic participation, and national security.

According to California State Superintendent of Public Instruction Bill Honig, 46 percent of projected job openings by 1995 will require training usually associated with college. This figure represents an 8 percent increase over the jobs requiring this preparation in 1982.(12, p. 14) Increased technology and international competition will require a workforce that is educated, productive, resilient, and adaptable. Unfortunately, many experts fear that our educational system is inadequate for producing workers of this type and that we are moving toward a two-tiered society in which the uneducated are not only unemployed but unemployable. This situation is costly to the public, as society pays for the welfare and other costs of those who are unproductive. It is also costly in terms of political stability. A permanently uneducated segment of the population is unlikely to have the skills needed to participate in community or civic life or to realize their full potential as human beings.

What Is the Magnitude of the Drop-out Problem? The problem's enormity is complicated by the difficulty in obtaining good data. However, the data that are available indicate that things are bad. For example, approximately 25 percent of the students entering high school nationwide, a total of almost one million students per year, will drop out.(3, p. 18) This rate varies from state to state and ranges from 10 and 45 percent. The 973,000 drop-outs from the nation's high schools in 1981 will lose $228 billion in personal earnings over their lifetimes, while society will lose $68.4 billion in taxes.(6, p. 7)

Youth unprepared to meet the challenges of the future presents a serious problem for the country. As the Committee for Economic Development says in a recent report:

> If present trends continue without corrective actions, American business will confront a severe employment crisis. This scarcity of well-educated and well-qualified people in the work force will seriously damage this country's competitive position in an increasingly challenging global marketplace. Current projections point to a serious labor shortage in only a few years. By 1990 the impact of new technologies is expected to drive total private-sector demand for employment to 156.6 million jobs, nearly twice that in 1978. If these estimates are only close to the mark, there will be a shortage of over 23 million Americans willing and able to work.(2, p. 4)

What Is a Drop-out? Most of the data collection difficulties center on developing a common definition of *drop-outs*. A student who withdraws from school without graduating from high school or enrolling in another school is usually referred to as a drop-out. However, schools and communities remain unable to establish uniform definitions or determine at what point a former student is labeled a *drop-out*.

A study conducted by the Council of Chief State School Officers found differences among all the states in their approaches to tabulating drop-out data. The study results indicate that "29 states do not collect any data on expelled students; 33 do not collect any data on suspended students."(3, p. 19) Some states and districts count students who enroll in private schools or move to other districts as drop-outs, while others merely cease to include these students in their enrollment count; some schools label as drop-outs students who earn GEDs or join the military after leaving school prematurely, while others do not because these students are essentially still in the education system.

Why Do Students Drop Out? Findings from several studies reveal that:

- About two-thirds of all drop-outs leave school because of poor grades or because they feel that school is not for them.(9, p. 14)
- Young men commonly leave school because they cannot get along with teachers (31 percent) or have been expelled or suspended (18 percent).(9, p. 14)
- Young women often drop out because they are getting married (38 percent) or are pregnant (23 percent).(9, p. 14)
- Thirty-eight percent of drop-outs report leaving school early to work.(9, p. 14)
- Twenty-three percent of young children aged zero to five in America are living below the poverty line. Factors such as inadequate housing and health care, substance abuse, and overcrowding interfere with a child's learning ability.(5, p. 3)
- The three demographic characteristics most strongly related to dropping out of school are socioeconomic status, race and ethnicity.(10, pp. 5-10)
- Students who drop out are dissatisfied with school, have lower self-esteem, and have no plans for post-secondary education.

What Happens to Drop-Outs? School drop-outs have two options: 1) They can survive on their limited education, or 2) they can continue their education by either returning to school or getting a high school equivalency diploma.

According to the *High School and Beyond Survey*, almost half of the drop-outs eventually choose to continue their education. The study found that almost 38 percent return to school and either graduate or earn their GEDs.(8, p. 19) By doing so, their futures brighten.

On the other hand, drop-outs who do not complete their education have far fewer options available to them. For most the future is bleak:

- According to the GAO, in 1986 youth drop-outs were less likely than high school graduates to be in the labor force--68 percent of drop-outs were in the labor force compared with 87 percent of high school graduates aged 16-24.(8, p. 22)
- Eighty-two percent of America's prisoners are high school drop-outs.(5, p. 15)
- If employed, youth drop-outs have limited opportunities--only 8 percent of male drop-outs are employed in technical, administrative support, and sales occupations, while 20 percent of male graduates have jobs in these fields.(8, p. 26)

- The limited employment opportunities translate into differences in cumulative lifetime earnings. Estimates show that the expected lifetime earnings of drop-outs are approximately one-third less than those of high school graduates.

To compound the frustration surrounding the problem of students dropping out of school, experts disagree about how schools should respond to academically poor students. On one hand, many advocacy groups claim that schools do nothing to retain academically poor students who misbehave and are over the compulsory attendance age. Other groups, notably those involved in the excellence in schools movement, recommend that students who choose not to make the effort to graduate should be allowed to drop out and therefore not weaken the school experience for other students. Additionally, many of the students who are having difficulty in school are also having problems out of school; they may live in poverty, come from broken homes, or may be teen parents. Therefore, the education system is not the only system serving these children; social services, mental health, or juvenile justice may also serve them. The service delivery, though, is usually fragmented and not coordinated through policy efforts.

The intensified public awareness regarding drop-outs has prompted widespread and varied responses. These include business and school district services for at-risk youth and state-local pilot projects for drop-out prevention.

In spite of these and other efforts, the problem of students dropping out of school has remained unchanged over the past two decades. During that same period of time, the national economy has faltered. The answers to both problems are interrelated.

Federal Policy

While education is a major national concern, it does not occupy much space on the federal policy agenda, as is evidenced by the U.S. Department of Education's $20 million budget, of which $4.7 billion is spent on K-12 education. The federal government provides only about 8 percent of all money spent on public education. Education in the United States is a state and local responsibility.

The federal role in drop-out prevention has been twofold: supplementing existing state efforts and guaranteeing quality education for all students. Toward those goals, federal funds traditionally have been used to reduce inequities in educational opportunities by aiding handicapped, disadvantaged, or non-English-speaking children. The School Dropout Demonstration Assistance Program, created in 1988, is the only federal program specifically devoted to reducing the drop-out rate. It provides $23.9 million in grants to school districts and local organizations to: 1) identify potential drop-outs and prevent them from leaving school; 2) encourage drop-outs to re-enter school; 3) identify and assist at-risk students in the elementary and early secondary grades; and 4) collect and report data on drop-outs to school officials.

Other major federal education programs that affect potential drop-outs are:

- Bilingual programs for students with limited English proficiency;
- Chapter One of the Education Consolidation and Improvement Act of 1980, which provides remedial services in basic skills to educationally disadvantaged students;
- The Chapter Two program of the same act, which (through block grants to the states) distributes about $500 million annually to local districts for improving the quality of education;
- Special education programs, which annually spend $3 billion to provide support for the education of handicapped children and adults; and

- Vocational education programs, which provide approximately 10 percent of all the money spent nationwide in that area for improving existing programs and expanding programs for special populations.

The following are other federal programs that address the drop-out problem:

- The Interstate Migrant Student Record Transfer System tracks the health and educational records of children of migrant families through a computerized system. When migrant children move, their new school district contacts each public or private agency to access the computerized data. Located in Little Rock, Arkansas, the national computer data base disseminates information to school districts as needed. All states, except for Hawaii and some U.S. territories, participate at a state level. However, since district-level participation is optional, involvement varies from state to state. Federal funds support the system.

- For more than 20 years, the federal government has attempted to help disadvantaged youth make the transition from school to work through programs that enhance skills and provide work experience. The two oldest programs for poor and minority youth are the Job Corps and Summer Youth Employment programs. Job Corps provides basic education, vocational training, and support services. Summer Youth Employment provides more limited services to larger numbers of disadvantaged youth, typically providing work experience up to 10 weeks during the summer. It serves 750,000 youth annually.

- In 1982 Congress approved the JTPA, a training program for disadvantaged adults and youths. The law requires 40 percent of JTPA funds to be spent on programs for youth, including high school drop-outs.

State Policy

Although all states have acknowledged the problems related to students' dropping out of school, few have taken serious steps toward addressing the issue. Initiatives for drop-out prevention exist in nearly all states, but few are comprehensive in nature. Most initiatives have begun on a pilot basis with no commitment of continued funding. Most also do not address the whole child and the variety of issues that can confront him from educational to personal to financial problems.

States face formidable challenges in developing comprehensive responses to such problems. Although the tide is turning, drop-outs still are not a top priority. Developing statewide drop-out prevention initiatives is difficult. Inadequate data bases, structural barriers to interagency collaboration, limited resources, and local resistance to state activism are but a few of the obstacles to be overcome. However, recent efforts indicate that progress is being made. Highlights of those efforts follow:

- In 1987 Arizona enacted the Dropout Prevention Act, allowing certain districts to raise local taxes for funding drop-out prevention programs. Under this law, local revenue control limits can be exceeded, allowing the district to spend more per pupil than would normally be allowed under the equalization spending formula. To qualify, a district's drop-out rate must be 1 percent or more of the student population in grades 9-12. In addition, to be eligible, a district must have a drop-out prevention plan for students in grades 4-12.

- Jobs for Connecticut Youth (JCY) was initiated in 1981 to unite state and local resources for those at risk of dropping out of school. JCY has improved the current and future

employability of at-risk youth. The Connecticut Department of Education, with additional support from a variety of sources, provides the majority of funds. Those other sources include an Edna McConnell Clark Foundation grant, JTPA funds, and community and private sector money. JCY programs have served almost 10,000 youth.

- In 1987 the Connecticut General Assembly passed An Act Concerning Dropout Prevention, which appropriated $750,000 to the 25 districts with highest need. Competitive grants for additional districts were also provided by earmarking a 5 percent set aside. The newly created programs must collaborate with community agencies, local businesses, and the private sector. Additionally, the legislation specifies that the State Board of Education must adopt a policy to identify at-risk youth, develop services for them, and coordinate efforts of state agencies that serve them.

- In 1986 the Florida Legislature passed the Dropout Prevention Act, recommending that every district establish a program for serving at-risk youth. In addition, legislators allocated funds from general appropriations to establish 17 community-based programs and 16 teen parent programs in selected districts throughout the state.

- As part of its Education Reform Package passed in 1985, Illinois created the Truancy Alternative and Optional Education Program. It focuses on prevention, a long-term process aimed at the elementary and middle school levels, and intervention, which provides attendance options for those at immediate risk of quitting school. Competitive grants for program development are available to districts and are funded as a categorical line item of the reform package.

- In 1985 the Massachusetts General Court created the Essential Skills Dropout Prevention Grant Program that provides discretionary grants to schools for implementing grade 7-12 drop-out programs. To be eligible for the competitive grants, the districts must have high concentrations of students from low-income families and documented high drop-out rates. In addition, school applicants must appoint an advisory panel of students, educators, and representatives from business and community agencies. The program is funded through a line-item budget appropriation.

- Legislation creating High School Graduation Incentives was passed by the Minnesota Legislature in 1987. It empowers schools to provide graduation incentives, such as alternative high school attendance or post-secondary school, to at-risk or drop-out-prone students ages 12-21. Since its implementation in July 1987, the program has served 1,200 students.

- Created by the Texas Legislature in 1987, the Dropout Reduction Program requires that districts meet certain criteria in order to receive funds. Each must supply an at-risk coordinator to collect data and oversee programs, create a drop-out information clearinghouse, and form an interagency coordinating council to address the needs of at-risk youth.

- The 1987 Washington School Retention and Retrieval Program (implemented in September of 1987) allows districts with the highest drop-out rates to develop programs for those at-risk students and for youths who have already dropped out of school. Through a categorical line item, funding of $5.2 million is provided to 60 districts--the 15 with the highest percentage of drop-outs, and the remainder chosen on a competitive-award basis.

- In West Virginia, the Comprehensive Dropout Prevention program was created to complement previous legislation, which required guidance counseling services for grades

7-12, by requiring the same services for grades K-6. Additionally, the program mandated that all county boards of education develop a comprehensive drop-out prevention program. Counselors and administrators are required to work together to develop plans, with funding provided through basic foundation program appropriations.

- Through Wisconsin's Children at Risk program, the Department of Public Instruction assists school boards and communities in designing, planning, and implementing drop-out prevention programs in grades preschool to 12. The law requires each local school board to identify children at risk, develop plans to serve their needs, and monitor and evaluate programs.

- The Iowa General Assembly enacted several initiatives in 1989 to serve children at risk through interagency collaboration. One initiative established the Child Development Coordinating Council--made up of representatives of the Departments of Human Services, Public Health, Education, and Human Rights and child development specialists--to award grants for preschool programs for at-risk youth. Another provides funds for four to six school-based youth services programs. At middle or high schools, the programs must provide mental health, employment, health, and educational services. Delivery of these services, however, may be designed by the local school.

- In 1989 the Utah Legislature created the Council for At-Risk Children and Youth--made up of representatives from the executive offices of the Departments of Education, Health, and Social Services--to develop and implement comprehensive school-based services for at-risk students in grades K-3. Local collaborating committees (principals; mental health, social services, and health authorities; local substance abuse authorities; teachers; and parents) may design grant applications for pilot programs to provide these services. By mandating that representatives from various child-serving agencies be involved in the program design and implementation, the legislature is encouraging programs to serve multiple needs of children.

Other state legislation addressing the drop-out problem includes:

- In 1987 Arkansas enacted legislation to create statewide drop-out reporting data collection procedures.

- In Iowa local revenue control limits can be exceeded by districts raising property taxes, issuing bonds, or utilizing enrichment levies to increase the local budget for drop-out prevention programs.

- The Minnesota Legislature created Area Learning Centers in 1987 to help at-risk youth and drop-outs develop academic, trade, and vocational skills and gain work experience in order to graduate from high school.

- To be accredited, every school in Mississippi must prepare a five-year drop-out prevention plan and reassess it yearly. Although the plans are designed for K-12 students, the focus is on students who fail the eighth grade basic skills test.

- North Dakota formed the Children's Services Coordinating Committee to study the youth at-risk problem and determine program development options. The committee consists of representatives from the governor's office, the attorney general's office, the chief justice's office, and other governmental agencies, including the Indian Affairs Commission.

- In 1986 the Virginia General Assembly appropriated $480,000 from general funds for 18 Dropout Prevention Grants. Support for actual programs went to 12 districts, and six received funding for planning or training. Each of the districts chosen had higher than average drop-out rates.

Key Points

When developing public policies to prevent students from dropping out of school, the following points should be considered:

- Nearly one million children drop out of school each year.
- Drop-out rates for rural students are as high or higher than those of urban youth.
- According to the Committee for Economic Development, for every dollar spent on early prevention and intervention, six dollars can be saved in the costs of remedial education, welfare, and crime.(2, p. 15)
- According to researchers Berlin and Sum, if the mean tested skills of this nation's 19- to 23-year-olds could be raised by one grade equivalent--a goal easily attainable via most computer-assisted remediation programs, lifetime earnings would increase by 3.6 percent, out-of-wedlock births would decline by 6.5 percent, welfare dependency would decrease by 5.3 percent(1, p. 42), and criminal arrests would decline by 6.2 percent. In 1986 only 49 percent of America's noncollege-bound high school graduates were working full-time.(4, p. 22)
- By the year 2020, according to Harold Hodgkinson of the Institute for Educational Leadership, one out of every three Americans will belong to a minority group.(2, p. 9) His research shows that minorities are more prone to drop out of school. The drop-out rate for blacks is 50 percent higher and the rate for Hispanics is twice that of their white counterparts.
- Over 64 percent of the drop-outs who have jobs receive minimum wages.
- Many systems, including social services and juvenile justice, are serving the same youths who are having problems with education in a fragmented, duplicative, and costly manner.
- The Bureau of the Census provides the best estimate of the national drop-out rate: The national percentage of adults ages 18-24 with three or fewer years of high school is 23.9 percent.
- By diverting energy and resources away from the educational enterprise system, drop-outs contribute to the disruption of the overall education system.
- Coordination of resources and services available to the child and the child's family can be the foundation of comprehensive services that meet the needs of the at-risk youngster.
- Research shows that children who enter school with inadequate health care, little exposure to education in the family, and emotional/social problems are likely to fall behind, stay behind, and drop out.
- In future years, according to the Institute for Educational Leadership, the drop-out problem will worsen due to changing U.S. demographics: that is, aging general

population, expanding minority youth population, growing numbers of children in poverty, and destabilization of the traditional American family.

- Sixty percent of prison inmates dropped out of school.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following legislative actions for preventing students from dropping out of school:

- Develop data-gathering systems capable of tracking state and national trends.
- Provide alternative programs that make it easy for students to return to school after dropping out. This means developing programs that are flexible, supportive, and don't discourage older students from participating.
- Concentrate on equitable distribution resources for prevention programs to adequately fund poorer school districts, which often have the largest number of potential drop-outs.
- Support studies that analyze the impact of the education reform movement, various support programs, vocational education programs, and other education initiatives on students at risk of dropping out of school.
- Attack the drop-out problem by creating early intervention programs that focus largely on child care, early childhood education, and training new parents to help their children learn.
- Evaluate the effectiveness of school counseling programs and other support services, and shift the focus of those programs toward a more proactive approach that reaches more students and meets their emotional, social, and educational needs.
- Foster interagency collaboration among schools, other youth-serving agencies, governments, and community organizations involved in resolving the drop-out problem.
- Challenge the assumptions about how schools and classrooms are operated. This means encouraging innovative curricula; stressing variations among pedagogical strategies and skills; regrouping students; developing better evaluation mechanisms for students, schools, and educators; and involving parents in site-based school management approaches.
- Promote strategies that strengthen school-parent-student relationships. Parents and schools can work together to create positive learning environments. Research has shown that schools and parents can unite to improve the academic success of children significantly.
- Create a special standing commission on at-risk youth to analyze the nature of the problem and recommend a plan of action.
- Assign responsibility for drop-outs to a single cabinet-level agency.
- Charge the chief state school officer in each state with developing a set of recommendations for the legislature and state board of education on ways to restructure schools to meet the needs of at-risk youth.

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ADOLESCENT PREGNANCY

Commentary

The United States has the highest rates of teenage pregnancy, birth, and abortion in the Western world.(3, p. 1) Of all 16-year-old unmarried girls, approximately one-third of whites and one-half of blacks reportedly have had sexual intercourse.(3, p. 2) Over 25 percent of teenagers never use contraceptives, and nearly 40 percent use contraceptives sporadically.(3, p. 3) As a result, each year more than one in 10 American girls aged 10 to 19 becomes pregnant.(3, p. 1) While the rates of teenage pregnancy remain consistent, it is important to note that the actual numbers of teen pregnancies and births are declining as a result of the decreasing number of teens in the population.

Teenage pregnancy and parenthood are associated with numerous socioeconomic and medical problems. Rarely are teenagers prepared for the potential consequences of early parenting, such as low educational achievement, unemployment, single parenting, poverty and welfare dependency, pregnancy-related health complications, infant mortality, and child abuse.

To illustrate, only one-half of teenage mothers complete high school by age 29.(3, p. 6) As a result, they are more likely to be unemployed or have low-status, low-paying jobs. They are also more likely to be dependent on public assistance.

Family instability further complicates a teenage mother's financial security and the future of her child. Nearly half of all teenage mothers give birth out of wedlock; of these, 93 percent attempt to raise their babies themselves.(3, p. 3) This trend, combined with the fact that teenagers suffer higher rates of divorce and separation than older couples, means that many female teenagers are heading single-parent households.(3, p. 6) A majority of these households lack adequate subsistence; in fact, 75 percent of single mothers under age 24 live below the poverty line.(3, p. 6)

The problem of poverty is exacerbated by the fact that teenage mothers have nearly twice as many children as older women.(3, p. 6) These children often continue the cycle of family instability and welfare dependency and become pregnant themselves at an early age. While consequences of adolescent pregnancy are dire, teen mothers are able to "catch up" over time if early intervention strategies are implemented to control fertility, complete education, and secure employment.

The states bear the burden of teenage pregnancy in terms of lost human potential and mounting welfare expenditures. Sixty-one percent of females under age 30 who receive AFDC had their first children as teenagers.(4, p. 135) Moreover, deliveries to adolescents account for 30 percent of all hospital deliveries paid for by Medicaid.(3, p. 5)

Deliveries constitute only part of the medical bill paid by the states. Teenage mothers are more likely to die or suffer from pregnancy-related health complications than mothers in their early twenties.(3, p. 6) The babies of teenagers are at a 39 percent greater risk of having a low birthweight, a major cause of infant mortality and various illnesses.(3, p. 7) Injuries and defects cause disabilities if a child is lucky enough to survive the defect. Most doctors believe that many of these health problems could be prevented if teenage mothers were receiving adequate prenatal care, but many are not.

Recent studies show that the children of teenage parents are at greater risk of health problems, low intellectual and academic achievement, social behavior problems, and teenage

pregnancy.(5, p. 5) Most of these outcomes are related to the socioeconomic and cultural conditions under which children of teenagers live, however, as opposed to being a direct result of teenage childbearing.

Federal Policy

Federal policy did not address teenage pregnancy as a specific and unique problem until 1978. Prior to that time, the issue was handled in the context of maternal/child health and family planning, with teenagers served only as a subgroup of the larger eligible population.

In 1967 the Child Health Act (Title V of the Social Security Act of 1935) was passed for the purpose of reducing infant mortality. Federal maternal and child health funds were made available to local health departments to provide comprehensive perinatal care to low-income teenagers and their children.

Three years later, the Family Planning Services and Population Research Act (Title X of the Public Health Services Act of 1970) was passed to support family planning projects. Federal funds were used to make contraceptives more accessible to low-income women and to develop more reliable methods of contraception, train personnel, and produce and distribute educational materials.

In 1978 Congress passed legislation that, for the first time, focused on teenage pregnancy as a problem meriting special attention. The Adolescent Health Services and Prevention and Care Act of 1978 (Title VI of the Health Services and Centers Amendments Act) made funds available to help develop comprehensive services for pregnant and parenting teenagers. The Office of Adolescent Pregnancy Programs in the Public Health Service was established to administer the act and to coordinate all federal efforts related to teenage pregnancy. In three years, 38 local projects received grants through the program. In 1981 the act was repealed, and the funds went into the Maternal/Child Health Block Grant.

The Adolescent Health Services Act was replaced in 1981 with the Title XX Adolescent Family Life Act, which emphasizes preventing early sexual activity and providing care to pregnant and parenting teenagers. The key prevention strategy is abstinence with the promotion of strong family values; and the key pregnancy resolution strategy is adoption. Services to pregnant and parenting teenagers are available through federally funded short-term research and demonstration projects. Once the projects are proven effective, the federal government hopes that state and local funding will continue to support the programs. Contraceptive services are not a major focus of the act, but federal policy does provide for these services under Title X.

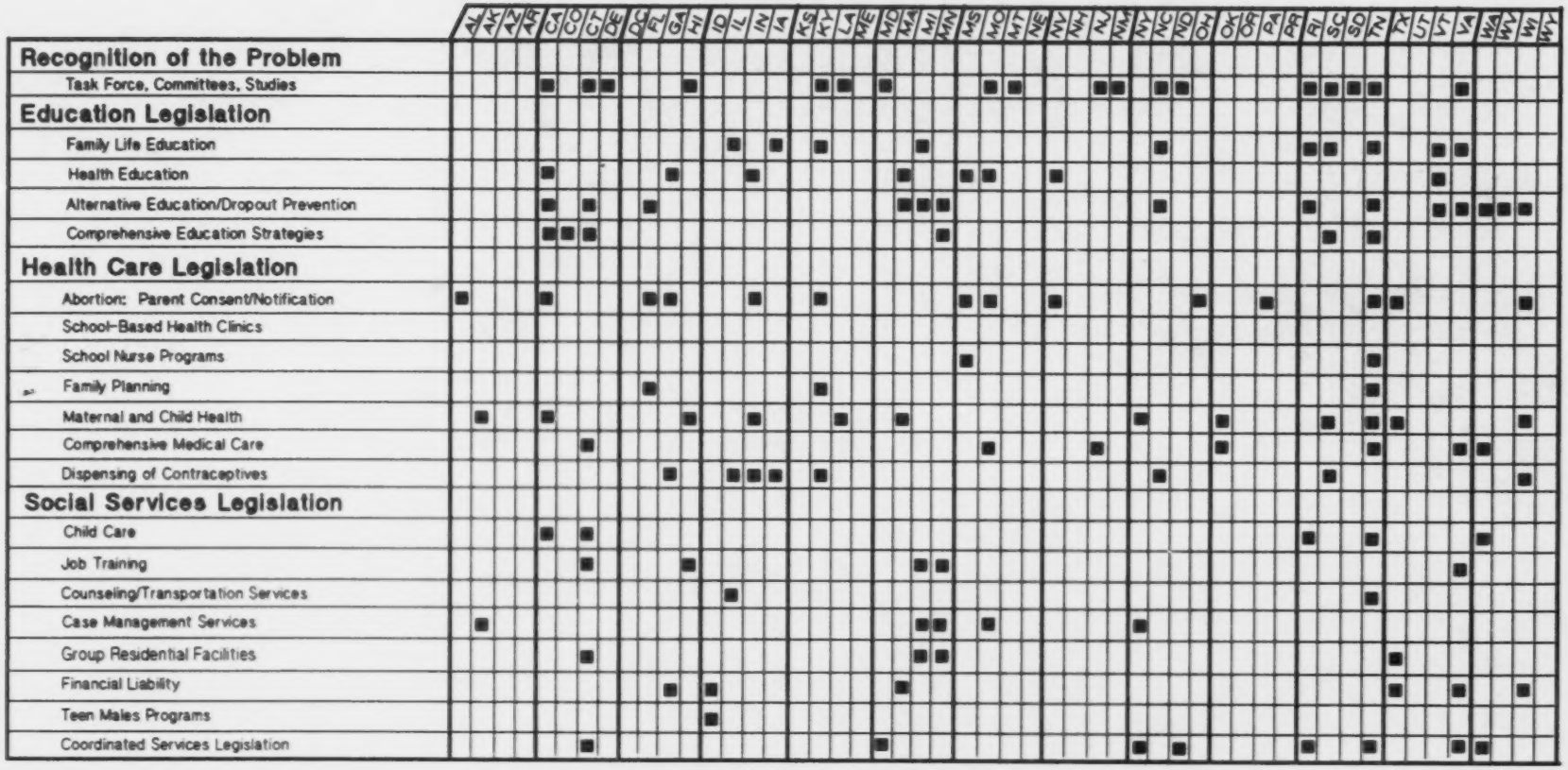
In 1978 the Carter administration amended the Family Planning Services and Population Research Act (Title X) to require specifically that programs provide services to teenagers. Today, this is the largest federal initiative addressing the problem of teenage pregnancy. More than one-third of women served under the program are teenagers. The act encourages, but does not require, that parents be notified regarding their minor daughter's decision to obtain contraceptives.

State Policy(1)

There has been a dramatic increase in state legislative activity related to teenage pregnancy over the past few years. Currently, 38 states have enacted and 48 states have introduced teenage pregnancy legislation. Just three years ago, only nine states had enacted and 23 had introduced teenage pregnancy legislation. Legislative task forces to study the teenage pregnancy problem have been proposed in nearly one-third of the states. Funding from the state legislatures for teenage pregnancy programs is increasing. (See Table 3.)

Table 3.

State Acts on Teenage Pregnancy and Parenting Through October 1988


AL AK AZ AR CA CO CT DE DC FL GA HI ID IL IN IA KS KY LA ME MD MA MI MN MS MO MT NE NV NH NJ NM NY NC ND OH OK OR PA PR RI SC SD TN TX UT VT VA WA WV WI WY
Recognition of the Problem
Task Force, Committees, Studies
Education Legislation
Family Life Education
Health Education
Alternative Education/Dropout Prevention
Comprehensive Education Strategies
Health Care Legislation
Abortion: Parent Consent/Notification
School-Based Health Clinics
School Nurse Programs
Family Planning
Maternal and Child Health
Comprehensive Medical Care
Dispensing of Contraceptives
Social Services Legislation
Child Care
Job Training
Counseling/Transportation Services
Case Management Services
Group Residential Facilities
Financial Liability
Teen Males Programs
Coordinated Services Legislation

Note: Entries do not reflect single pieces of legislation. Each act is categorized according tothe various topics addressed by the act. Therefore, a single piece of legislation containing provisions for several programs, for example, is recorded in several categories.

Source: National Conference of State Legislatures, June 1989.

Current legislation, while comprehensive in the scope of issues it addresses, reflects two trends. First, bills emphasize coordinating services and programs for the pregnant and parenting teenage population. For example, legislation requiring state departments to work together and integrate new programs with existing services has become common.

Second, schools are a focal point for many pregnancy prevention strategies. Students are generally required to attend school; therefore, schools provide a captive audience for programs such as family life education and school-based health clinics (SBHCs), as well as daycare services for parenting students.

SBHCs--more than 100 such facilities in 28 states--provide comprehensive health services to students in or near the schools that they attend. Minimal legislative activity has occurred on this issue in recent years. Four states introduced bills to establish and fund SBHCs in 1988, but none was enacted. Currently, most SBHCs are developed by local community groups and foundations.(2, p. 4)

In 1988 New Jersey created the School-Based Youth Services Program. The state Department of Human Services established it in 29 communities with the mandate that each program coordinate its services with existing community organizations. Individual sites are managed by selected middle schools, high schools, and nonprofit agencies that demonstrate sufficient support from local parent organizations, youths, teachers, industry, and human service providers. Since April 1988, more than 10,000 teenagers have received 37 program services that include job training, child care, health care, family counseling, instruction on parenting skills, and substance abuse counseling services. The program's original $6 million budget forgave grants of up to $250,000 per site. The program has gained considerable legislative and executive support because of its comprehensive approach, and state funding for 1989 was renewed at $6 million.(1, p. 6)

Another prevention-oriented program, the Maryland system of Family Support Centers, provides services for young families with children under three years of age. The prevention-oriented programs help teen parents avoid additional unplanned pregnancies, complete their education, acquire job skills, and become better parents. Maryland's four pilot centers were started in 1985 with a $500,000 budget--$400,000 in legislative allocations through the Maryland Department of Resources and $100,000 in private donations. Continued legislative support has helped the program grow to a total of 11 centers, with a legislative allocation of $1,375,000 and a total budget of $2 million. Program evaluation for the 1986-87 and 1987-88 school years shows that 50 percent of the participants returned to educational programs within six months, and 75 percent returned within 18 months. In addition, the repeat pregnancy rate for program participants was 9.5 percent, less than a third of the national average. The employment rate for participants increased from 11 percent at intake to 31 percent within six months.(1, p. 6)

Other issues on legislative agendas include:

- *Alternative Education/Dropout Prevention*. This legislation aims to help a pregnant or parenting student obtain a high school degree through either a regular school or a non-traditional program (California, Connecticut, Florida, Maine, Michigan, Minnesota, North Carolina, Rhode Island, Tennessee, Vermont, Virginia, Washington, West Virginia, Wisconsin).

- *Parental Consent/Notification for Abortion Services*. This is one of the most lively teenage pregnancy issues. Such legislation requires unemancipated minors to receive parental permission or to notify parents before receiving abortion services. States with this type of legislation include Alabama, California, Florida, Georgia, Indiana, Kentucky, Mississippi, Missouri, Nevada, Ohio, Tennessee, Texas, and Wisconsin.

- *Maternal and Child Health*. Providing for teenagers' perinatal health needs and care of their infants is the major thrust of this legislation (Alaska, California, Hawaii, Indiana, Louisiana, Maine, New York, Oklahoma, South Carolina, Tennessee, Texas, Wisconsin).

- *Grant Programs*. State grant programs provide money for pilot projects to test new approaches to solving the problem of teenage pregnancy (California, Hawaii, Iowa, Maine, Minnesota, New York, North Carolina, Ohio, Rhode Island, Tennessee, Wisconsin).

- *Family Life Education*. Family life education is a comprehensive approach to teaching human sexuality. It typically covers the topics of human development and reproduction, family planning, interpersonal relations, decision-making skills, and positive role modeling. Instruction is provided as part of the regular curriculum and can be adapted to any grade level (Illinois, Iowa, Kentucky, Michigan, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, Virginia).

- *Health Education*. Health education is designed to teach adolescents the biological facts of human sexuality and the risks of sexually transmitted diseases. Unlike the more comprehensive family life education, very little training in decision-making or family planning is provided (Georgia, Massachusetts, Mississippi, Missouri, Nevada, Rhode Island, South Carolina, Vermont).

- *State-Level Coordination*. This legislation requires that state departments work together to offer comprehensive services to the pregnant and parenting teenager population (Connecticut, Maryland, New York, North Dakota, Rhode Island, Tennessee, Virginia, Washington.)

- *Coordinated Medical Care*. This legislation requires the coordination of comprehensive health services for a pregnant teenager or young mother and her child under one department or agency (Connecticut, Missouri, New Jersey, Oklahoma, Tennessee, Virginia, Washington).

- *Dispensing of Contraceptives*. This legislation prohibits the dispensing of contraceptives to minors in schools and in community clinics (Georgia, Illinois, Iowa, Kentucky, North Carolina, South Carolina, Wisconsin).

- *Financial Liability*. Requiring parents to be financially responsible for the offspring of their minor children is the newest legislation strategy (Georgia, Idaho, Maine, Texas, Virginia, Wisconsin).

- *Miscellaneous Education Strategies*. Legislation in this area seeks to combine education programs or offer additional programs such as parenting courses, counseling services for teen parents, or outreach to teenage males (California, Colorado, Connecticut, Minnesota, South Carolina, Tennessee).

- *Case Management Services*. Legislation to improve case management for pregnant and parenting teenagers usually requires having one counselor, or case manager, assist the teen client in obtaining all needed services (Alaska, Michigan, Minnesota, Missouri, New York).

- *Daycare Services*. Under this legislative strategy, teenage parents are provided the financial and informational resources they need to obtain daycare for their children so that the parents can continue their education or seek employment (California, Connecticut, Rhode Island, Tennessee, Washington).

- *Job Training*. This legislation assists teenage parents in obtaining skills necessary for entry into the workforce (Connecticut, Hawaii, Michigan, Minnesota, Virginia).

- *Group Residential Facilities*. This legislation provides for the establishment or funding of residential maternity homes for pregnant and sometimes parenting teenagers (Connecticut, Michigan, Minnesota, Texas).

Key Points

In examining the problem of teenage pregnancy, the following points need careful consideration in the development of sound public policy:(4, pp. 262-293)

- Legislators should focus on the prevention of teenage pregnancy, rather than services after the fact, as preventive interventions are less costly in human and financial terms.

- To prevent pregnancy, teenagers must be given the motivation and ability to do so. Teenagers who are not sexually active must be encouraged to delay sexual activity. Teenagers who are already sexually active must have access to contraceptives and must be trained to use the contraceptives correctly and diligently.

- Interventions aimed at teenage males must be included in any public policy strategy dealing with pregnancy or parenting. It is not just a women's issue.

- Teenage pregnancy is a complex problem requiring educational, health, and socio-economic solutions. Any public policy that attempts to deal with the problems must be comprehensive in its scope.

- Strategies must take into account the socioeconomic, cultural, religious, moral, attitudinal, and experiential differences of communities and individuals. There should be a wide variety of policies and programs that meet the needs of different groups and philosophies.

- It is important that policy addresses the special needs and problems of dealing with youth at highest risk. Young adolescents, the poor, and racial minorities face graver consequences when they become pregnant. It may be most beneficial to target these groups.

- Legislators, state agencies, communities, parents, and teenagers should cooperate and coordinate their efforts, remembering that government's role should supplement, not detract, from the role of the family.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action for sound public policy on teenage pregnancy:

- Support programs that seek to increase teenagers' awareness of their life options and the importance of abstinence so that they will be more motivated to avoid pregnancy. Life-planning, school drop-out prevention, employment and job-training, and role model and mentoring programs are examples.

- Support programs that seek to help teenagers delay becoming sexually active. In this regard, states should consider providing family life education, assertiveness and decision-making training, peer counseling, and responses to the irresponsible depiction of sexual behavior by the media.

- Support policies that encourage consistent and proper contraceptive use by sexually active teenagers. Policies that make contraceptives physically and financially accessible are essential. Media campaigns and health programs are also considerations.

- Support programs that make pregnancy testing and objective, nonjudgmental perinatal counseling available and accessible to teenagers. Consider policies that encourage teenagers to involve their parents and their partners in the planning and decision-making process.

- Support programs that provide medical, psychological, and social support to those teenagers who choose to relinquish their infants to adoption.

- Support programs that provide early and regular prenatal care, health education, nutrition services, accessible labor and delivery services, and contraceptive services to those teenagers who choose to give birth.

- Support programs directed at the birth of a second child and the delay of repeat pregnancies.

- Support policies that seek to ensure the economic well-being and self-sufficiency of teenage families, including programs such as paternity establishment, child support enforcement, job training, and AFDC. These policies should emphasize the responsibility of the young fathers and provide services to enable them to support their children.

- Support programs that seek to increase the self-sufficiency of teenage families. Some examples of these programs are life management training, educational support and remediation, employment and job training, and improved access to child care and transportation services. These programs need to distinguish between teen parents living at home and teens whose independent living requires special services such as housing.

- Support programs that seek to improve the well-being of teenage parents such as parenting education programs, pediatric health care, and nutrition services.

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INFORMAL FAMILY CAREGIVING FOR ADULT FAMILY MEMBERS (18-100+)

Commentary

Family and informal caregiving is flourishing in the United States. Approximately seven million Americans are caregivers. Family care has traditionally been provided by spouses, daughters, and daughters-in-law whose numbers are increasing in the workforce. Based on benefit industry estimates, 20 percent of the workforce is now faced with having to care for an elderly relative, and that number is growing.(3, p. 9) On the average, a caregiver employed outside the home spends 47 hours each week providing care to an elderly or adult family member who lives with the caregiver, exceeding the time spent at a job. Family caregivers who do not work outside the home spend an average of 18 hours per day giving care.(11, p. 2) Families, not governmental agencies, provide the majority of care needed by older persons living in the community. Often caregiving can be stressful and conflict with other responsibilities such as employment, personal needs, and the needs of other family members.

Currently, caregiving is defined in a broad sense to include a spouse, relative, or friend who has primary responsibility for the care of a functionally disabled adult and does not receive financial compensation for the care. The adult family member usually needs continuous care or supervision and is at risk of placement in a long-term care facility, if the caregiver is not assisted by home and community support services. This broad definition permits examination of the full range of circumstances in which caregivers experience the effects of caregiving.(5, p. 2) The absence of informal caregivers is correlated highly with the likelihood that an elderly or disabled person will become institutionalized.

The American Association of Retired Persons (AARP) and the Travelers Companies Foundation conducted a national survey of caregivers for the elderly in 1987. The following is the AARP profile of caregivers and care receivers based on the survey:(2, pp. 8-11)

- Seventy-five percent of caregivers are female. The average age is 45 with 28 percent under 35 and 15 percent over 65. Sixty-six percent are married. Only 37 percent share a household with the care recipient. Approximately one-third of caregivers became caregivers because they live in close proximity to the older person; 18 percent because they have a closer relationship with the older person and 25 percent because no one else would do it. Caregivers reported the additional responsibility of caring for children, as 31 percent reported children in the household under 12 years of age and 23 percent reported living with children 12 through 17 years old.

- Fifty-five percent of caregivers are employed; 42 percent are employed full-time and 13 percent are employed part-time. Thirty-three percent of full-time employees and 37 percent of part-time workers have lost time from work due to caregiving responsibilities. Fifteen percent of those previously employed chose early retirement, and 12 percent reported giving up work entirely while they were helping their older relative. Nine percent reported taking a leave of absence; 4 percent reported problems with supervisors; and 3 percent turned down promotions. Of those who lost time from work, many went from full-time to part-time employment or had to take a leave of absence. Twenty percent lost benefits as a result of losing time at work or arriving late due to caretaking duties.(2, p. 36)

- Care recipients are generally relatives of the caregiver (85 percent), most likely a mother. Fifty percent live in their own home or apartment. Fifty-eight percent are housebound, and 28 percent of the housebound older persons are also bedridden. Twenty-four percent are wheelchair-bound. The average age is 77, with 13 percent between 50-64 years of age, and 24 percent 85 years old and older. Care receivers are most likely to suffer from chronic illness (70 percent); acute illness (16 percent); and both (5 percent).(2, p. 12)

Projections for the year 2000 show that 40 percent of functionally dependent Americans will be under 65 years old.(1, p. 11) There are many people under 65 who are disabled, chronically ill, and in need of rehabilitation services. Most of these people receive care at home. Their long-term care needs may be caused by a birth defect, rare disease, trauma, or other catastrophe. Approximately 40 percent of people who need personal assistance, because of the inability to perform one or more "activities of daily living," are under age 65. The 1983-1985 Health Interview Survey showed the following numbers of people to be in need of personal assistance because of restrictions in ability to perform one or more activities of daily living:(6, p. 106)

Need for Personal Assistance in Activities of Daily Living

Age 5 - 17	148,000 (6%)
18 - 64	866,000 (34%)
Over 65	1,507,000 (60%)

Baby boomers, people now entering their forties, are being called the "sandwich generation," since they're caught between caring for young children and parents.(3, p. 9) A daughter is caregiver to an older parent and frequently has teenage children. Researchers have characterized these caregivers as "women in the middle." Women generally live longer than men, and these middle-aged women, who experience the stresses of multiple roles and expectations as workers, spouses, filial caregivers, providers of care for others, parents, and even grandparents, may themselves be vulnerable to chronic conditions requiring long-term care.(7, p. 4) An estimated 1.8 million women nationwide are sandwiched between caring for children and frail relatives.(12, p. 36)

The policy emphasis at the federal and state levels is on preserving informal support and financial and service strategies that make it easier for spouses and relatives to care for the elderly and disabled in their own homes.(7, p. 1) The formal support structure of government assistance programs is characterized as bureaucratic and structured, requiring specialized skills and knowledge that cannot encompass all the individual preferences and needs for a service. Informal support services are seen as flexible, able to respond quickly, and able to meet special needs.

Growing numbers of elderly, increasing concern for the needs of disabled persons, and continuous efforts to contain costs have stepped up state efforts to provide community-based services as alternatives to more costly institutional care.(4, p. 41) States have developed alternative care delivery systems to provide assistance to families of elderly or disabled individuals unable to care for themselves. The intent is to increase or maintain the capacity of an individual to remain in the community, to prevent individual and family breakdown, to postpone or avoid the need for institutional care, and to prevent abuse by the caregiver.

A variety of services are available to provide relief care for families or other caregivers of disabled adults age 18 and over, including in-home and out-of-home respite care, daycare and overnight care, and 24-hour care for several consecutive days. Respite care services include all the

services usually provided to a disabled adult by his or her caregiver, such as supervision, personal care, and health-related care.

A marked absence of national policies to provide a full continuum of health care from the hospital to the home is evident. Critics argue that, while Medicare is based on an acute care model, Medicaid is biased toward institutionalization.(9, p. 106) Respite care receives extremely limited government assistance. Federal and state home health assistance for family caregivers of the chronically ill is spotty at best, experts say.

At the state level, inadequate, fragmented, and inconsistent funding of respite care services appears to be the dominant pattern. This is consistent with similar difficulties that states have experienced while attempting to develop other community-based long-term care services.(7, p. 9) The financial cost of maintaining someone in the community, especially for those persons just above Medicaid eligibility, can be devastating. Those receiving care include people whose incomes are too high for government assistance but who cannot afford to pay for needed services.(10, p. 11) According to the AARP survey profile, 47 percent of caregivers have household incomes greater than $25,000, 20 percent have incomes less than $15,000, and 10 percent reported incomes of $50,000 or more.(2, p. 10)

Federal Policy

The federal government, states, and localities facing the challenge of meeting the long-term care needs of current and future generations will need creative solutions to finance and provide respite care and other community and family support services to assist those who care for elderly or disabled relatives and friends.(7, p. 26)

A number of federal legislative initiatives have been proposed to address the concerns of informal caregivers. Some focus on creating a greater awareness of the important role of families, friends, and other unpaid helpers in providing long-term care. Others support research and evaluation activities designed to examine alternative ways of addressing the problems of informal caregiving. Several encourage the development of services targeted to the needs of family caregivers.(13, p. 58)

Most notably, the Medicare Catastrophic Coverage Act of 1988, enacted in June 1988, contained provisions to pay for limited respite care provided by an unpaid family member or friend of a chronically dependent Medicare recipient.

The secretary of the U.S. Department of Health and Human Services was required to study out-of-home services, such as adult daycare and to report to Congress within 18 months of enactment. The secretary was to make recommendations on the advisability of providing out-of-home services to beneficiaries eligible for in-home services. Unfortunately, the provision of the law relating to respite care was repealed by the U.S. House of Representatives. Although the Senate bill retained the provision, final resolution of the law was uncertain at the time of publication of this report.

State Policy

State administrative responsibility for respite programs is closely tied to the sources of financing and the populations served. The coordination and assessment of respite care services with other family and in-home supports are appropriate and desirable avenues for state activity on this issue.(7, p. 10) Problems that states address include fragmented and uncoordinated services that may be available to one disability group but not another; programs designed for the convenience of providers, but not designed to help families stay together; services provided outside the home without secondary support (e.g., transportation) to enable families to use these services; and services unavailable in a timely manner, often available only after serious damage has been done.

In 1987 Delaware established an Elderly Housing Counseling Program within the Division of Aging to develop and coordinate a continuum of housing options for older Delawareans. Services provided by the program include information and referral, assessment (including in-home assessment when needed), consultation and planning, and advocacy. In 1989 legislation passed to include, under the Elderly Housing Counseling Program, accessory apartments and other innovative housing options for elderly citizens who are homeowners or renters. Accessory apartments are those created in the surplus space of single-family homes. They help the elderly stay in their homes by providing rental income, security, and services in exchange for rent reductions. This new law enabled the program to provide information to the elderly and the community; to convene realtors, local zoning agencies, nonprofit organizations, lenders, and home health agencies to facilitate the use of accessory apartments; and to counsel the elderly, their families, and potential renters.

A number of states enacted legislation in 1988 concerning respite care:

California extended the Department of Aging program until January 1990 to provide respite care for eligible frail elderly and functionally impaired persons and their caregivers both in the home and out of the home.

A *Connecticut* law created a respite care pilot program for the elderly by appropriating $75,000 to the Department of Aging. The program enables the elderly to volunteer as a respite care provider in exchange for respite care credits to be used in the future. A private, nonprofit service provider will be designated to receive the grant to establish the program.

A resolution adopted in *Delaware* clarifies that the purpose of its Statewide Respite Care Program is to provide care for the aged, disabled, physically handicapped, and mentally ill individuals who reside in the community with their families or other caretakers. The resolution further states that families and caretakers are expected to contribute toward the cost of respite care based on their financial ability. The Department of Health and Social Services is required to establish guidelines for the administration of the program and report to the General Assembly on the status of the program.

Florida's Community Care for Disabled Adults Act assists disabled adults, ages 18 to 60 years old, in continuing to live in their communities. The act funds a continuum of services, including medical therapeutic services, home health aide services, home nursing services, emergency response services, case management, adult daycare, escort services, home-delivered meals, respite care, and transportation. The Department of Health and Rehabilitative Services must provide the legislature with biennial evaluations beginning in October 1989.

Kentucky passed legislation to fund a program of essential services that prevent unnecessary institutionalization of elderly persons with physical or mental limitations that restrict their ability and impede their capacity to live independently. Essential services include chore services, home-delivered meals, home health aide services, homemaker services, respite services, escort services, and home repair services.

Maryland expanded the scope of its respite care program to include short-term care of individuals who have a functional disability.

Nebraska designated the Health and Human Services Committee to conduct an interim study to determine the needs of caregivers for the elderly, including but not limited to an analysis of the need for services, including respite care allowances and support for in-home services; an identification of methods available for information and referral; and other needs of caregivers for the frail elderly.

New Jersey legislation established the Home Care Expansion Program funded with Casino Revenue Fund monies to provide home health care, medical daycare, nonemergency medical

transportation, case management, social adult daycare, homemaker and respite care to elderly and disabled persons. The cost of care will be limited to an annual amount based on a percentage of the cost of nursing care. Services are to be provided when medically necessary and to avoid institutionalization.

A *New York* statute extends the duration of its Respite Demonstration Program for frail or disabled adults through 1989.

North Carolina budget legislation directed the Division of Aging in the Department of Human Resources to use $1,008,000 of its appropriation for the 1988-89 fiscal year for services that support family caregivers of elderly persons with functional disabilities, whether physical or mental, who want to stay in their homes rather than be institutionalized, but who need assistance with the activities of daily living. Services that may be purchased include respite care, adult care, stipends for senior companions, and other related services. The legislation also enabled the Division of Aging to contract for technical assistance, which is to include training assistance, coordination of the various service delivery and funding sources, and ideas for innovative ways to build a lasting system of services for family caregivers.

Key Points

As state legislatures continue to deliberate public policy regarding family caregivers and adult care receivers, the following key points should be considered:

- Informal sources of social support comprise one of the largest components of the long-term care delivery system in the United States.(5, p. 1) A large percentage of the supportive services provided to children, adults with disabilities, and people who are elderly is delivered by family members and friends.

- Research shows that most elderly and disabled are institutionalized not because of a change in health status but because of a change in marital status and living arrangements, such as the death of a spouse or the inability of a child to care for them.(7, p. 3) An individual desiring to remain living independently in the community will turn first to an informal system of caregivers. Their involvement avoids or postpones institutionalization.

- Family caregiving is to be encouraged by legislators, policy analysts, and the public. However, innovative alternatives must be developed to support the family caregivers,(7, p. 5) including public/private partnerships.

- State governments have led the experimentation with adult daycare, respite care, and other alternatives to support family caregivers and delay institutionalization.

- In a survey of families providing care for adult or elderly members, 52 percent needed information, 38 percent needed respite services, and 35 percent needed emotional support.(11, p. 3)

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to address the issue of family caregiving for adult care receivers:

- Encourage state policy support for family caregivers to help deter or postpone institutionalization of adult family members.
- Increase state support of and encourage private sector investment in family respite services.
- Provide information and support to enable families to provide or purchase care for their adult family members.
- Focus attention on the topic of caregiving through public policies and private sector activities that reinforce and support families and friends as caregivers, including public education on aging and available caregiver resources, recognition and support groups for family caregivers, respite and adult daycare programs, tax incentives to informal caregivers, payment to families for care provided to their own relatives, and a wide range of home and community-based services.
- Increase community support for caregivers: Educate community services organizations about the needs of caregivers, and educate caregivers about local community and private sector resources.
- Draft laws to reflect start-up and future program activity costs in order to negotiate contracts, publicize new services, conduct publicity and outreach efforts, target clients before beginning service delivery, and review assessment and data collection systems.
- Promote alternative housing options, such as accessory apartments, to permit elderly citizens to live independently.
- Encourage more public/private partnerships for support services and independent living arrangements.

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PREVENTION OF LOW BIRTHWEIGHT IN NEWBORN BABIES

Commentary

The United States ranks last among 17 industrialized nations in infant mortality. Most infant deaths occur as a result of low birthweight; babies are born too small or too soon. The incidence of both low birthweight and infant mortality for black infants is twice that of whites.

Low birthweight babies are almost 40 times more likely to die during their first four weeks of life than normal birthweight infants. For those babies that survive, more than $2.5 billion is spent annually in the United States on intensive hospital care for sick newborns, primarily due to conditions associated with low birthweight. In addition, about 11,000 low birthweight babies who survive each year have long-term disabilities that result from being too small. Disabilities include mental retardation, cerebral palsy, blindness, developmental delays, and learning disabilities.

State governments spend millions of dollars annually to purchase health care for low birthweight babies, both through Medicaid and through funds paid for uncompensated hospital costs for uninsured patients. In addition, states pay for a portion of the long-term needs of eligible disabled babies, including their medical needs, screening, special education, counseling, foster care, and institutional care.

Table 4.
Infant Mortality Rates, 1985
(Deaths per 1,000 live births)

Japan	5.5	
Finland	6.3	
Sweden	6.7	
Switzerland	6.9	
Denmark	7.9	
Canada	7.9	
Netherlands	8.0	
France	8.1	
Norway	8.3	
Ireland	8.9	
United Kingdom	9.4	
Belgium	9.4	
West Germany	9.5	
East Germany	9.9	
Australia	9.9	
Spain	10.5	(1983)
United States	10.6	

Source: U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345 (Washington, D.C.: U.S. Printing Office, February 1988).

However, the problems and expense associated with infant mortality and low birthweight babies often can be averted with proper nutrition and prenatal care for pregnant women. Several national studies have documented that babies of mothers who receive no prenatal care are three times as likely to suffer low birthweight, contributing to greater risk of birth defects and death. A 1985 report issued by the Institute of Medicine (IOM) indicated that for every dollar spent on prenatal care for high-risk, low-income women, as much as $3.38 worth of intensive medical care for high-risk infants can be saved.(7, p. 22)

Early and comprehensive prenatal care can also lead to savings beyond the first year of life. The U.S. Congress Office of Technology Assessment estimates that "for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health care system saves between $14,000 and $30,000 in newborn hospitalization, rehospitalizations in the first year, and long-term health care costs associated with low birthweight."(14, p. 9)

State legislatures have deliberated health care cost containment issues for the last few years. They are beginning to address the socioeconomic inequities in children's health and nutrition programs, as a result of a new understanding of the importance of prevention and early intervention, which help keep children out of expensive health, social service, and special education programs. States are beginning to require an analysis of the cost benefits associated with existing, as well as new, programs. In turn, state governments have begun to realize that many of the high costs incurred to treat illnesses and disabilities can be prevented by adequate services to all pregnant women and their children.

Federal Programs

The Omnibus Budget Reconciliation Act of 1986 created new categories of persons eligible for Medicaid, including pregnant women and very young children with incomes below the poverty threshold. States are not required to provide cash assistance to the new recipients, but the federal government provides matching funds at the normal Medicaid rate for coverage. With 1987 amendments to the act, states could extend Medicaid coverage to pregnant women and infants with family incomes up to 185 percent of the federal poverty level, and to children ages one to eight whose family income does not exceed the federal poverty level (FPL). By July 1, 1990, all states must provide Medicaid coverage of prenatal care services to pregnant women with family incomes up to 100 percent of the federal poverty level.

The Maternal/Child Health (MCH) Block Grant program, which incorporates the previous Title V Maternal and Child Health program initiated in 1935 under the Social Security Act, provides grants to states for maternal and child health services to reduce infant mortality. States may determine services to be provided, with the exception of inpatient care, which is restricted to "high-risk" women and certain children. In 1986, $457 million was appropriated for the MCH Block Grant program, and states used a portion of their allocations for free or subsidized prenatal care in public health clinics, health education, outreach to pregnant women, and transportation services. The expanded eligibility under Medicaid gives states the opportunity to shift some populations currently served with MCH funds to Medicaid and use the block grant funds to expand MCH services.

Another important program for states to utilize in reducing the number of low birthweight babies is the Supplemental Food Program for Women, Infants, and Children (WIC), which provides nutrition counseling and food supplements for pregnant women and young children. Unlike Medicaid, the WIC program requires no state or local matching funds. Under new program changes, states and localities are prohibited from charging sales tax on WIC food purchases. States were required to enact this provision in state programs by October 1987. Although this program allowed more resources for actual food supplements for more clients, only 40 percent of all women and children eligible for WIC were served in 1986.

State Activity

By the end of 1988, at least 42 states and the District of Columbia had taken advantage of the new Medicaid options to raise the income eligibility level for pregnant women and infants to 100 percent of the federal poverty level or higher. As of July 1, 1989, states were required to cover pregnant women and infants whose family income does not exceed 75 percent of the FPL. A few states have extended Medicaid to 185 percent of the FPL, including California, Connecticut, Maine, Massachusetts, Michigan, Minnesota, Mississippi, and Vermont. Iowa and West Virginia adopted a standard of 150 percent of the FPL, and Wisconsin went to 120 percent of the FPL. (The FPL was $11,611 for a family of four in 1987.)

About half of all states have eliminated use of an assets test for pregnant women, an improvement also allowed under the 1986 federal budget act. This test usually disqualifies poor families with personal assets that have a value slightly above the allowable level and that cannot be used easily to provide adequate prenatal and maternity care, e.g., an automobile. Twenty-three states and Puerto Rico have adopted presumptive Medicaid eligibility for pregnant women, which allows prenatal programs to provide services immediately to patients likely to qualify, by using temporary Medicaid cards while their formal applications are being processed.

Although state legislation has focused on adopting Medicaid reforms, several states and localities are making additional advances in the fight to reduce the incidence of low birthweight babies:

- The Florida Improved Pregnancy Outcome (IPO) Program includes the following components: 1) medical risk assessment of preterm labor, with women designated high risk receiving intensive services, including care from the same clinician, weekly visits after 24 weeks of pregnancy, with cervical check, education to identify signs of preterm labor, nutrition counseling, and one prenatal and one postpartum home visit; 2) implementation of a statewide training program for service providers who train local staff; and 3) interprogram coordination to ensure that the IPO staff also conduct early and periodic screening, diagnosis, and treatment (EPSDT) of infants; automatically refer eligible mothers to WIC with program recertification at postpartum visits; and provide Medicaid application forms to IPO staff.

- The Indiana General Assembly approved a one-half cent increase in the cigarette tax to fund several new maternal and child health initiatives. These include $2.4 million to assist local health departments in furnishing prenatal care, well-child care, and nutrition services. In addition, $400,000 was appropriated to supplement the MCH Block Grant, and another $400,000 of state funds was allocated to supplement the WIC program. These appropriations mark the first time the state has allocated funds for these purposes.

- Michigan designated prenatal and postpartum care as a "basic health service," entitling all low-income women to prenatal care. The legislature also appropriated state money to supplement the federal WIC program and approved an increase in obstetrical fees paid for maternity care provided to Medicaid recipients.

- Minnesota raised its medically needy income level up to the federal reimbursement maximum of 133 percent of the payment level for AFDC. This change will add 23,000 new persons to the program, of whom more than two-thirds are children. The state also launched a program to provide prenatal care for pregnant women and outpatient services for children in families with incomes up to 185 percent of the poverty level. These services are provided under a new program called Right Start, which provides care on a sliding fee scale, adjusted for family income. The state has also supplemented the federal

WIC program with $1 million in state money, providing nutrition services to an additional 1,200 to 1,500 women and children.

- Mississippi expanded Medicaid eligibility to 185 percent of the poverty level for pregnant women and raised its limit on Medicaid-reimbursable inpatient hospital care for children from 15 to 30 days a year. This helps cover lengthy hospital stays for unhealthy newborns. The fee for maternity care was raised from $341.25 to $531.20. The state also instituted an aggressive outreach campaign to inform the public about the expansion of Medicaid services to pregnant women and children, including a hotline to answer questions, take complaints, and guide people through the system to expedite the application and service delivery process. Mississippi is also tackling its high teen birth rate through the Public Health School Nurse Intervention Program, which focuses on general health and pregnancy prevention education.

- The New Hampshire General Court appropriated $400,000 over the biennium to finance prenatal care for uninsured low-income women for the first time. Reimbursement fees paid to providers for maternity services for Medicaid recipients were increased by $390 to $566, depending upon the provider's specialization.

- In 1985, the North Carolina General Assembly appropriated $1.2 million to reduce infant mortality and enhance prevention of premature births. In allocating the funds to counties, the Division of Human Services required counties to initiate a scoring system to identify high-risk mothers. The state has a vigorous outreach program, which uses Medicaid for case management of maternity care. The case manager contacts all human services organizations for client referrals, conducts personal interviews and assessments, and follows the client to service completion. The program is reaching an estimated 90 percent of the targeted population. Evaluation is an important part of the program, linking data from child health clinics, the WIC program, and Medicaid. Socioeconomic and demographic variables will be extrapolated from the data.

- Rhode Island doubled Medicaid reimbursement rates for maternity services to $750 and provided Medicaid coverage for poor children in two-parent working families. In addition, the state established Rite Start, a program to furnish prenatal care, delivery, and postpartum services to uninsured pregnant women with incomes up to 185 percent of the FPL. Rhode Island also appropriated state funds to supplement the federal WIC program.

- Despite one of the most troubled economies in the country, Texas raised its funding level for its uncompensated health care programs, including prenatal and infant health care services, from $22.5 million to $31 million.

- Utah is able to provide prenatal care, transportation, and outreach to almost 2,000 more uninsured pregnant women at local health departments and community health centers because of the legislative approval of $1.7 million to expand Medicaid to pregnant women with incomes up to 100 percent of the FPL. The state appropriation was matched by $4.8 million in federal funds, which made the additional services possible. The state also launched a multimedia education effort, including a television campaign worth about $2 million, donated by a local television station over a two-year period.

- West Virginia increased the Medicaid reimbursement rate for obstetrical services per delivery from $225 to $600.

- The District of Columbia expanded the availability of affordable prenatal care by eliminating fees in its clinics for all uninsured pregnant women with annual incomes of less than $20,000.

Key Points

In examining the problem of low birthweight babies, the following barriers exist to adequate prenatal care:

- Poverty and insufficient resources to obtain services.
- Lack of medical insurance, including prepaid health plans, for low-income women.
- Lack of obstetricians and health care professionals, especially in rural areas, to provide prenatal care.
- Health providers' refusal to accept Medicaid payment for health services.
- Administrative barriers to Medicaid, which include complicated, long application forms requiring extensive documentation.
- Fragmentation of services, including eligibility regulations and uncoordinated services, that delay care.
- Applications for Medicaid that are separate from those of maternal and child health clinics.
- Inaccessibility of services for low-income pregnant women, including transportation, child care, convenient clinic hours, service delays through overscheduling and "block appointments," and appointment delays for needed services.
- Lack of receptivity by providers, including insensitivity to cultural variations and language problems.
- Lack of public education about the importance and availability of prenatal care and a lack of communication in health clinics about the health procedures provided to pregnant women.
- Patient fear and apathy.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative actions to reduce the incidence of low birthweight babies:

- Identify goals for reducing infant mortality.
- Adopt the new Medicaid option to increase the income eligibility for pregnant women and infants to 185 percent of the federal poverty level.
- Redirect federal MCH funds that are freed up by shifting clients to Medicaid to expand services to other low-income pregnant women who are not Medicaid eligible.

- o Appropriate state monies to supplement the federal WIC program.
- o Adopt state programs for medically indigent pregnant women to provide insurance coverage for or access to prenatal care.
- o Promote an aggressive public education campaign on the importance and availability of prenatal care.
- o Consider mandated insurance coverage of prenatal care services.
- o Fund prepaid insurance plans for prenatal care.
- o Create a pool of providers for underserved areas by using health funding, National Health Service Corps, and equivalent state programs to train low-income persons in medical service.
- o Enact legislative oversight of access to prenatal care to ensure more convenient hours, convenient locations to reduce transportation problems, and child care for low-income women receiving prenatal care.
- o Encourage states to share information about innovative uses of federal MCH program services.
- o Ensure reimbursement rates under public programs that resemble costs more closely.
- o Require that providers who participate in the Medicaid or the MCH programs participate in both.
- o Require providers to serve maternity patients enrolled in public programs, either at their offices or in local health clinics.
- o Enforce the federal law that requires payment for transportation to medically necessary care for a Medicaid patient, either by transporting the patient to the provider or bringing the provider to the pregnant woman.
- o Implement a case management system of care to assist pregnant women in identifying affordable transportation, child care, and auxiliary services near the home or the location of the provider.
- o Expand services under Title XIX (Medicaid) for prenatal care to include vitamins and nutritional supplements and counseling.
- o Cover additional providers under Title XIX, such as birthing centers and nurse midwives.
- o Establish uniform guidelines for the coordination of federal programs, such as AFDC, food stamps, WIC, and MCH Block Grants.

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COMBATTING SUBSTANCE ABUSE AND ITS EFFECT UPON FAMILIES

Commentary

Approximately 37 million Americans used an illegal drug last year; 23 million, or almost one in every 10 Americans, used an illegal drug in just the past month.(10, p. 2) Three out of every four teenagers drink alcohol regularly, and nearly 100,000 10- and 11-year-olds report getting drunk at least once a week.(14, p. 1) One out of every eight Americans is the child of an alcoholic.(4, p. 7)

The costs of this substance abuse are staggering. More than $200 billion is lost in the United States each year to the economic and social drain that substance abuse perpetuates. Crime, unemployment, lost productivity, chronic illness, abusive family relationships, and death are all direct consequences of drug and alcohol abuse by addicts and alcoholics.

The relationship between drugs, alcohol, and crime is clear. Nearly three-fourths of all persons arrested--for other than drug charges--test positive for illegal drugs or alcohol intoxication at the time of their arrest. Juvenile court judges report that 60 to 90 percent of their caseloads involve some degree of drug or alcohol abuse.(14)

According to the 1988 White House Conference for a Drug-Free America, the relationship between substance abuse and criminal activity "goes well beyond the commission of crime to support a habit"; substance abuse has "victims beyond conventional crime."(5, p. 3) These victims include the tens of thousands killed or maimed each year by drunk and drug-using drivers, the babies born addicted or abandoned at birth by addicted and alcoholic mothers, the 25 percent of AIDS victims who acquire the disease through intravenous drug use, and the children--some as young as seven and eight years old--recruited into drug dealing and gang activity.(9)

Also beyond conventional crime are the effects of substance abuse in American workplaces. Substance abusers account for more than $75 billion lost by U.S. companies each year in decreased productivity, absenteeism, accidents, and unrealized profits stemming from impaired judgment and creativity. Studies show that substance abusers are late and absent three times more often than non-abusing employees, use three times the average level of health benefits, are involved in accidents three and a half times more than other employees, and are five times more likely to file a workers' compensation claim.(11)

Even more destructive and irreversible are the consequences of substance abuse that victimize families. Drug and alcohol abuse are intergenerational phenomena--abusers pass on to their children not only the emotional, social, and financial havoc that drug and alcohol habits create but also a greater risk of developing addictions themselves. For example, the 29 million Americans who are children of alcoholics--seven million of whom are minor children currently living with alcoholic parents--are four times more likely to become alcoholic than their peers from nonalcoholic homes. Even the grandsons of alcoholic grandfathers are three times more likely to become alcoholics, and daughters of alcoholics are more likely to marry alcoholic men.(4, p. 8)

Children of substance abusers are placed for adoption or foster care more often, have greater incidences of behavioral and educational problems, and are more likely to become runaways. They are also more likely to be born with birth defects and fetal alcohol syndrome (FAS); treated for hyperactivity and aggressive conduct disorders; abused physically, emotionally, or sexually; committed

to adolescent psychiatric inpatient programs; pregnant and parenting as teenagers; adjudicated as juvenile crime offenders; and treated for substance abuse themselves.(4, p. 12)

Legislators increasingly are deliberating FAS. FAS describes a pattern of physical and mental birth defects that result from a woman's alcohol consumption during pregnancy. Babies with FAS are smaller in size and may never attain their developmental potential like other low birthweight or premature newborns are eventually able to do. The severity of this disorder varies, but FAS babies can develop permanent mental handicaps, including poor coordination, short attention spans, and behavioral problems. Between 3,600 and 10,000 babies are born each year with FAS.(17, p. 4)

Health experts estimate that nearly 375,000 newborns each year have been exposed to illegal drugs--frequently cocaine. Babies born with prenatal exposure to large amounts of cocaine are more likely to be born prematurely or to die before birth. These babies, like FAS babies, are often abnormally small and face increased risk of deformities or crib death. Evidence indicates that these babies suffer neurological damage affecting normal development. Currently, there is a shortage of medical facilities to treat pregnant women who have drug problems. For example, California reportedly has only five full-time drug treatment programs that accept pregnant women.(12, p. 104)

The problems associated with substance abuse are passed from parent to child. Without intervention, the family cycle of personal pain and societal costs continue. To help reduce generations of pain, suffering, and waste, intervention and prevention efforts are needed to get substance abusers and their families into recovery programs in addition to government efforts that target criminal drug activity.

Federal Policy

Recent U.S. policymaking has focused more on illegal drug use than it has on alcohol abuse and more on drug enforcement than on treatment and prevention. President George Bush has declared that the United States is "at war" with drug use and trafficking and has launched a $7.9 billion national antidrug campaign.(2)

Federal substance abuse efforts primarily target drug dealers and traffickers. Under the Bush plan, about two-thirds of federal money will go to law enforcement and about one-third to drug treatment and education. The federal government has defined its role as that of: 1) overseeing criminal prosecution of illegal drug users and traffickers; 2) organizing drug abuse prevention efforts at the federal level; and 3) encouraging drug education efforts by schools, the media, and private industry.(3)

In 1988 to facilitate more and effective criminal prosecution of drug users and dealers, Congress passed, as it did in 1984 and 1986, an omnibus antidrug bill authorizing $2.5 billion in expenditures. On March 9, 1989, President Bush appointed William Bennett as America's first drug "czar," who, under a 1987 executive order issued by President Reagan, heads the cabinet-level Office of National Drug Control Policy, which is charged with coordinating federal drug enforcement and prevention activities.(7)

With regard to prevention, more than half a dozen agencies, departments, and programs now share responsibility for efforts at the federal level. This diversified approach, which includes the National Institutes of Health and the Office of Substance Abuse Prevention in the Alcohol, Drug Abuse and Mental Health Administration, is consistent with the White House conference's recommendation that prevention be achieved "through multiple strategies that address the unique characteristics, cultural diversity and structure found in each community in America." For example, the Anti-Drug Abuse Act of 1988, in part, reauthorizes the Alcohol, Drug Abuse and Mental Health Block Grant. Through the grant, states may apply for funds by submitting state plans for prevention,

treatment and mental health services. Of the federal government's $3 billion in antidrug expenditures for 1988, approximately $506 million were spent on prevention campaigns.(13, pp. 1605-1606)

In educating the public about substance abuse, the federal government's role, as described by the 1986 House Select Committee on Narcotics Abuse and Control, has been one of "facilitator, rather than actor, and supporter, rather than provider." About $122 million in federal money was spent in 1988 on basic drug abuse research.(13, p. 1607) In 1988 the White House Conference for a Drug-Free America made nine education recommendations based on "four keys" to eliminating the use of illegal drugs and alcohol in schools, colleges, and universities: 1) strong leadership and unequivocal "no use" policies at all levels against drugs and alcohol; 2) parental and community involvement in the fight against illegal drugs; 3) training for all members of the community regarding drug and alcohol prevention; and 4) the active participation and cooperation of higher education institutions in the fight against drugs and alcohol.(10, p. 4)

In addition, the National Institute on Drug Abuse (NIDA), the Drug Enforcement Administration (DEA), and the Department of Education continue to promote research, provide a clearinghouse function, and emphasize the role of the private sector and the media.

State Activity

Successful substance abuse-related policies vary from state to state. In 1987 and 1988 alone, 133 laws related to substance abuse were passed in 37 states and Puerto Rico. These statutes address a range of concerns, including medical insurance coverage for drug and alcohol treatment, student drug testing, underage drinking, school drug education programs, drug trafficking, and civil immunity for school personnel reporting alcohol or drug use. Generally, state legislative initiatives can be categorized as addressing: 1) detection and treatment; 2) distribution and use control; 3) license revocation and suspension; 4) penalties and procedures; and 5) prevention and education.

Detection and Treatment. Thirty-one of the state substance abuse-related laws passed in 1987 and 1988 address detection and treatment. They include a 1988 Kentucky law that permits a parent or guardian to commit a minor to substance abuse treatment. Measures in 1987 and 1988 in Wisconsin and Rhode Island, respectively, establish procedures for minors to receive substance abuse treatment without parental consent. Other recent detection and treatment initiatives include:

- The California Youthful Drunk Driver Visitation Program, established by the legislature in 1987, which authorizes courts to require minors convicted of driving under the influence, as a condition of probation, to visit facilities that demonstrate the effects of drinking and driving; and

- Alaska's new requirement, under a 1988 law, that group medical insurance plans provide coverage for drug and alcohol treatment.

Distribution and Use Control. Thirty-one 1987 and 1988 state laws relate specifically to the distribution of drugs and alcohol. Distribution of crack to a minor is now classified as a separate crime under a new South Carolina initiative, and a 1988 Michigan law makes it a felony for an adult to include a minor in the commission of a criminal act such as distributing controlled substances. Examples of other state approaches are:

- South Carolina's 1988 law creates a separate crime for the distribution of crack to a minor and provides separate penalties for selling, distributing, manufacturing, or possessing a controlled substance within one-half mile of an elementary or secondary school; and

- Measures in 1987 and 1988 in California, Maryland, and Pennsylvania impose stricter rules and penalties with regard to identification cards and their illegal use for underage drinking.

License Revocation and Suspension. New laws in Alaska, Indiana, Louisiana, Oklahoma, and Washington allow for the revocation of minors' driving privileges based on drug- or alcohol-related offenses. A 1987 California statute provides for a 72-hour liquor license suspension when an establishment sells alcohol to a minor.

Penalties and Procedures. Forty state laws passed in 1987 and 1988 impose stricter penalties for illegal drug and alcohol use and allow for more drastic procedures to be taken by school personnel, police officers, and courts. Among them are:

- Statutes passed in 1988 in Maryland and Virginia granting civil immunity for school personnel reporting suspected student alcohol and drug use;

- Criminal laws passed in Kansas and Rhode Island in 1988 that impose mandatory imprisonment for persons convicted of selling certain drugs to minors; and

- Measures passed in 1987 and 1988 in California, Florida, Georgia, Oklahoma, and Rhode Island that stiffen penalties for both minors consuming alcohol and adults who facilitate underage drinking.

Prevention and Education. Twenty-five state laws passed in 1987 and 1988 address drug and alcohol prevention and education. A majority of these statutes pertain to the curricula and funding of school drug and alcohol education programs. In addition:

- A 1988 Florida law permits courts to assess special payments against defendants convicted of drug offenses, increases the tax on illegal drug sales, and provides for funds from these sources to be used for drug abuse treatment and education;

- A 1988 New Hampshire measure requires that brochures on FAS be distributed to couples applying for marriage licenses; and

- A 1987 Minnesota law requires that "chemical abuse advisory teams" be formed in schools to build awareness, identify prevention and treatment programs, and develop reciprocal notification procedures among parents, schools, and law enforcement agencies.

Key Points

In examining the problem of substance abuse and its effect upon families, the following points warrant consideration in the development of effective public policy:

- Alcohol is America's number one drug problem among youth--nearly five million adolescents have been identified as problem drinkers.

- Alcohol is a factor in nearly half of all accidental deaths, suicides, and homicides, including 42 percent of all deaths from motor vehicle accidents.

- The 26 states that raised their minimum drinking age between 1975 and 1984 showed an average 13 percent reduction in nighttime fatal automobile crashes among 18- and 19-year-old drivers.

- Alcohol is twice as popular among college students as the next preferred drug--marijuana --and more than five times as popular as cocaine.

- One to two out of every 1,000 live births are babies born with FAS.

- One out of every eight Americans is the child of an alcoholic. Of these 29 million Americans, seven million are minors currently living with alcohol-abusing parents.

- Substance abuse is an intergenerational phenomenon--children of alcoholics are four times more likely to become alcoholic themselves, and children of substance abusers, in general, are more likely to be abandoned; physically, emotionally, or sexually abused; treated for psychiatric disorders; adjudicated for juvenile crimes; and committed for psychiatric treatment.

- A survey of U.S. juvenile court judges shows that substance abuse is related to at least 60 percent of youth crime and possibly as much as 90 percent.

- Twenty-five percent of AIDS patients acquire the disease through intravenous drug use and the sharing of dirty needles.

- Substance abusers cost U.S. companies $75 billion each year in decreased productivity, absenteeism, and accidents.

- Federal substance abuse efforts primarily target drug dealers and traffickers. Of the $4 billion spent in 1987 federal antidrug efforts, $2.9 billion was spent on enforcement activity.

- Approximately $3 billion in federal money was spent on antidrug efforts in 1988--most went to enforcement efforts, with the exception of $506 million spent on prevention campaigns, $122 million used for drug abuse research, and $408 million allocated to drug treatment programs.

- States and private insurers carry 84 percent of the financial burden for drug and alcohol treatment programs.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative actions to reduce the social and economic losses perpetuated by substance abuse:

- Identify state goals for reducing the incidence of substance abuse.

- Recognize the intergenerational, cyclical characteristics of substance abuse and identify education, prevention, and intervention efforts as a priority for schools, private industry, and communities.

- Recognize the extent to which alcohol poses a greater threat to our youth and families than perhaps any illegal drug and pass laws that:

  * toughen penalties for adults and establishments who serve, sell, or otherwise provide alcohol to minors;

- revoke the driving privileges of minors who are apprehended for drug or alcohol-related offenses;
- provide for the temporary and immediate suspension of liquor licenses of establishments that sell or serve alcohol to minors.

o Require medical insurance coverage for drug and alcohol treatment of state employees and where employee health insurance is provided in businesses with at least 25 employees.

o Create separate criminal penalties for drug offenders convicted of selling or otherwise providing illegal substances, such as crack and cocaine, to minors.

o Create separate criminal penalties for drug offenders who hire minors to take part in drug-related sales or activities.

o Require that school health education, family life education, and other teenage pregnancy prevention courses include information on FAS.

o Encourage states to adopt legislation to identify infants born with FAS or substance abuse problems for appropriate child protective, health, or rehabilitative services.

o Promote an aggressive public education campaign on the economic and social costs of substance abuse.

o Promote an aggressive public education campaign on the intergenerational, cyclical family aspects of substance abuse.

o Require the state and encourage private companies and corporations to draft, and regularly update, drug and alcohol policies that provide for the education of managers on identification of possible substance abusers, as well as staff on substance abuse and treatment options. Also provide informational state assistance to the private sector.

o Prohibit reprisal against, or retaliatory discharge of, employees who take a minimal leave of absence for the purpose of entering drug and alcohol treatment programs.

o Grant civil immunity for school personnel who report suspected student drug or alcohol use, provided such reportings adhere to established administrative procedures.

o Provide for procedures whereby minors assessed as dependent on drugs or alcohol may petition the juvenile court for a waiver to enter substance abuse treatment programs without obtaining parental consent.

o Provide for procedures whereby parents or guardians of minors assessed as dependent on drugs or alcohol may petition the juvenile court to commit such minors to substance abuse treatment programs.

o Improve state facilities for treating drug and alcohol abuse.

o Develop strict standards for licensing private providers and make available lists of accredited facilities.

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YOUTH SUICIDE

Commentary

Each day in the United States, approximately 1,000 adolescents attempt suicide--and 18 succeed.(7, p. 49) In fact, suicide is the third leading cause of death among teenagers after accidents and homicide.(8, p. 2)

Concerned by a 300 percent increase in youth suicide over the past 30 years,(3, p. 19) legislators have recently begun to re-examine their role in suicide prevention, discarding outdated legislation criminalizing suicide in favor of early identification and treatment strategies. It was relatively simple to identify youths who attempted suicide and punish them under former laws. Identifying a youth with suicidal tendencies for prevention efforts is a more difficult task. Nevertheless, legislators in at least 11 states have embraced this challenge, working in conjunction with teachers, parents, teenagers, state agencies, and community groups.

Certain facts are known about the youth who attempt to and do kill themselves. Whites commit suicide twice as often as blacks; males five times as often as females.(3, p. 20) While the males are more successful in their attempts, females attempt suicide 10 times more often.(3, p. 20)

This untimely and unnecessary death is usually preventable if at-risk youth are treated in time. Ninety-five percent of youth who attempt to kill themselves are not really sure they want to die--they are just desperate for attention and help.(3, p. 18) Four out of five talk about killing themselves before attempting suicide.(3, p. 19) Unfortunately, by the time this blatant symptom of suicidal tendencies is recognized, in many cases suicide can't be prevented. Among young suicide victims, two-thirds have undergone psychological counseling and one-third have been hospitalized for suicide attempts.(7, p. 49) The key is early identification of youth at risk for suicide.

Researchers have linked youth suicide to a long list of risk factors. Some blame changes in American family life, since half of suicide victims come from single-parent families.(7, p. 50) The loss of a father is noted to be particularly stressful, especially on young boys.(8, p. 2) While losing a family member to death or divorce can be events leading to suicide, losing a close family member to suicide increases the chances of youth suicide ninefold.(7, p. 50)

Family conflict and abuse are common in the backgrounds of victims. Ninety percent of youth who attempt suicide complain that their parents don't understand them, and 75 percent have seen a doctor within four months of an attempt.(3, p. 20) Many suicidal youth are frequently truant from school and in trouble with the law.(7, p. 49) In two-thirds of suicides, substance abuse is involved, especially alcohol abuse,(3, p. 20) and as many as two-thirds of runaways are acutely suicidal.(2)

Psychologically, youth who attempt suicide seem not to have developed adequate methods for coping with normal adolescent social and academic strain. Especially vulnerable to any threat, pain, stress, or failure, they tend to try to escape their problems. As they withdraw, they isolate themselves from their peers, who soon reject them, increasing their isolation. The physical isolation of living in a rural area can dramatically increase a youth's emotional isolation and is also a strong predictor of suicide.

In addition to withdrawal, many youth who attempt suicide exhibit other anxiety disorders such as loneliness, shyness, tenseness, and extreme perfectionism. They are often impulsive,

hyperactive, and restless. They are above all unhappy, viewing themselves as outcasts at school, disappointments at home, and exiles in the community.

Societal factors also play a part in youth suicide. For example, increased access to guns has made survival of a suicide attempt much less likely today than 30 years ago. Sixty-two percent of young suicide victims end their lives with guns.(1, p. 2)

Unemployment, underemployment, dread of atomic warfare, the influence of self-destructive movie stars and music idols, and the sensationalism of teenage suicide by mass media have also been linked to youth suicide.

One to five percent of all youth suicides occur as the result of a group pact and are referred to as "cluster suicides."(6, p. 1) Another phenomenon seen among youth is the "copycat suicide," whereby a youth will commit suicide after reading or hearing about another youth's suicide.

No matter what the cause, the death of an adolescent by suicide is deeply traumatic to the victim's family, friends, and community and is a terrible waste of human potential for the state.

Federal Policy

For the most part, the federal government has not made funding of comprehensive youth suicide prevention programs a policy priority. There have been a few initiatives in recent years.

For example, in 1985 the federal government established the Youth Suicide National Center to serve as an information clearinghouse, develop and distribute educational materials, produce educational programs, and coordinate and support efforts to reduce youth suicide nationally. The center, in cooperation with the Administration for Children, Youth, and Families of the U.S. Department of Health and Human Services (DHHS), sponsored a National Conference on Youth Suicide in the summer of 1985. As many as 500 mental health and allied service professionals, educators, researchers, and government officials attended the conference and heard some of the nation's top experts on suicidology speak.

That same year, HHS Secretary Margaret Heckler established a high-level DHHS task force on youth suicide chaired by the director of the National Institute of Mental Health (NIMH). For its part, the NIMH has funded research studies into psychosocial and biological risk factors predicting suicide. It also has sponsored a public awareness campaign on depression, called Depression/Awareness, Recognition, and Treatment, which may have led to the identification of at least some presuicidal youth.

In 1985 an Adolescent Suicide Hotline was established under the federal Runaway Youth Act of 1974. The Runaway Youth Act, renamed the Runaway and Homeless Youth Act in 1980, provides funding for shelter, counseling, follow-up and support services, and a National Runaway Switchboard. Since studies have shown that a majority of runaways are suicidal,(2) the Adolescent Suicide Hotline was a natural extension of services for runaways.

Federal funding for youth suicide prevention programs mainly has been limited to block grants. For example, the Omnibus Budget Reconciliation Act of 1981 made block grants available to states for mental health, alcohol abuse, and drug abuse services. Such monies can be used for suicide prevention programs.

State Policy

Prior to 1984, suicide was a criminal offense in many states. That year, the last state statute outlawing suicide and providing for the punishment of people who attempt it was repealed.

Legislators began to view suicide public policy more in terms of prevention and intervention than punishment.

The first bill designed to assist schools and communities in preventing youth suicide was passed in 1983 in California.(4) This law provided for the development and funding of a statewide youth suicide prevention program. The program emphasizes cooperation between the schools and community-based suicide prevention agencies. It allows for classroom instruction in decision making, the dangers of substance abuse, suicide prevention, community resources, and enhancing school interpersonal relationships, as well as community-based initiatives such as peer group counseling, telephone hotlines, data collection, intervention and follow-up care, and parent/teacher education and training. States with similar programs include Maryland and New Jersey.(5) To date, states that have followed suit with prevention legislation include:

- *Florida*--1984 Fla. Laws, S.B. 529 requires state agencies to develop a comprehensive state plan for the prevention of youth suicide in cooperation with local groups and organizations.

- *Illinois*--1987 Ill. Laws, P.A. 85-297 and P.A. 85-721 provide for the evaluation of adolescent suicide prevention programs and teacher training.

- *New York*--1988 N.Y. Laws, Chap. 491 establishes the Adolescent Suicide Prevention Program to provide grants to public or private schools or not-for-profit organizations to increase awareness of identification and treatment options. State law (1988 N.Y. Laws, Chap. 53) also provides $7 million for the Youth-At-Risk Fund, which provides a total of $14 million in grant monies for services that include youth suicide prevention education.

- *North Carolina*--1987 N.C. Sess. Laws, Chap. 873 establishes a study commission to examine the causes of youth suicide; the relationship between substance abuse, child abuse, and suicide; monitoring, treatment, and intervention strategies; state and federal funding; coordination of services; and the need for a state plan. Other states with similar state-mandated task forces or study groups include Connecticut, Illinois, and Virginia.

- *Rhode Island*--1986 R.I. Pub. Laws, Chap. 546 provides for the incorporation of suicide prevention awareness programs in existing health education courses and appropriates funds for teacher training and the printing and distribution of appropriate educational materials.

- *Virginia*--1988 Va. Laws, S.J. Res. 15 encourages local school divisions to establish school-based suicide prevention programs and provides for the reporting of suicides and suicide attempts by children under 10, prevention services, and coordination of new and existing services.

- *Wisconsin*--1985 Wis. Laws, Chap. 29 provides for the development of the teacher training programs that will educate teachers in positive emotional development of adolescents, detection of suicidal tendencies, prevention of suicide attempts, and coordination of school suicide prevention programs with state and local agency programs. The law also provides for technical assistance to schools for the implementation of suicide prevention programs and coordination with other state agencies.

Key Points

In examining the problem of adolescent suicide, the following points should be considered when developing public policy:

- Nearly all youth who attempt suicide are uncertain about whether they want to die; rather, they are seeking attention. Therefore, suicide is usually preventable if at-risk youth can receive the attention and help that they need.

- The causes and symptoms of suicidal tendencies can vary according to the socio-economic, cultural, religious, moral, attitudinal, and experiential differences of communities and individuals. Understanding these causes and symptoms is important to the early identification and treatment of suicidal youth.

- Some suicide risk factors, such as dysfunctional coping patterns, surface early in a child's life. If youth at risk for suicide are identified and treated before adolescence, they will have a better chance of coping successfully with the stresses of their teenage years.

- Since most youth attend school and school-related stress accounts for many suicide attempts, suicide prevention efforts should be concentrated in the schools. However, to ensure the full use of all possible resources, school-based programs must be linked with a broad range of community programs.

- Because of the strong link between substance abuse and youth suicide, prevention education should include a drug and alcohol abuse component.

- The importance of the peer group cannot be underestimated. Any counseling strategy must provide for peer interaction.

- Liberal gun laws mean that youth have increased access to a weapon that can ensure successful suicide. If denied access to guns, youth seeking alternative suicide methods would be forced to use less effective methods for which the chance of rescue and survival is greater.

- Once a suicide occurs, it is essential that the victim's family, particularly siblings, and other youth in the community receive immediate counseling and referrals.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative actions for sound public policy for the prevention of youth suicide:

- Continue to support policies that focus on preventing youth suicide through early identification and treatment rather than policies that seek to deter suicide by punishing those who attempt it.

- Support research into the causes and symptoms of suicidal tendencies in youth, such as requiring stricter reporting and monitoring guidelines and the formation of broad-based study groups for data collection.

- Require programs for suicide prevention in the public schools, especially those programs that emphasize coordination with state and local agencies, the private sector, and other organizations and that include instruction in effective decision making, the dangers of substance abuse, and awareness of community resources. Encourage these programs in private schools.

- o Support community-based resources for suicide prevention and treatment, especially those that provide information, education, counseling, peer group counseling, telephone hotlines, parent/teacher training, coordination and referrals, and secure placement and care of suicidal youth.

- o Support programs that provide teachers and parents with education and training in the early detection of suicidal tendencies, prevention of suicide attempts, and awareness of community resources.

- o Support programs that facilitate parent/teacher/youth communication and parenting education programs that teach parents how to raise emotionally healthy children.

- o Support programs that seek to prevent youth from dropping out of school, particularly those that identify and treat learning disabilities early in the educational process.

- o Support programs that provide counseling and referrals to families plagued by problems such as divorce, child abuse, and substance abuse.

- o Support strict enforcement of existing gun control statutes.

- o Limit unsupervised access to firearms by children under 18 years of age.

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RESPONSES TO TODAY'S MENTAL HEALTH PROBLEMS

Commentary

Mental illness disorders represented the third most costly class of health care expenditures in 1980.(6, p. 5) During 1980, total expenditures for mental health care in the United States were estimated to be between $19.4 billion and $24.1 billion.(9, p. vi) The direct and indirect expenses, such as lost productivity and increased use of social services, are tremendous costs to society. Costs are especially high for the severe mental problems of childhood, which can produce lifelong debilitation.

Problems in defining chronic mental illness, gathering reliable data, and locating persons with mental illness create difficulties in determining the population's size. Currently, there are at least three million people in the United States suffering from severe mental disorders. Of these three million, the 1.7 to 2.4 million who suffer prolonged, severe disabilities constitute the seriously or chronically mentally ill population.(6, p. 5) These people either reside in institutions or live within the community in a variety of residential settings.

In the adult population, the most disabling forms of mental illness are schizophrenia and the affective disorders of clinical depression and manic-depressive disease. Affective disorders are characterized by disabling mood changes of severe depression, elation, or both. These disorders also may be accompanied by delusions and hallucinations. Although schizophrenia affects a small percentage of the population, it is the most expensive and devastating of all the mental illnesses. Victims of this disease may experience delusions, visual and auditory hallucinations, thought disorders, and other disruptive symptoms. At this time, there is no effective prevention or cure for schizophrenia and affective disorders.

In addition to their often disabling illnesses, persons with serious mental illness are subjected to discrimination and poverty. They are disproportionately poor, often lacking the intellectual, psychological, and financial means to lead normal lives. They face daily discrimination in housing, employment, education, and health care. Eligibility standards and administrative regulations often restrict their access to critically needed programs and benefits.

Mental illness also can be devastating to families. Approximately one-half of those with serious mental illness reside independently or with family members.(5) Families in which a member suffers from a serious mental illness face a multitude of stresses in their daily lives. They require special support services, must ensure that services are available in their communities, must deal with a variety of service professionals on a regular basis, and must make sure that the family member with the special needs is receiving services. In addition, families with special needs must balance their lives and give support and attention to the needs of all family members.

It is clear that current treatment does not "cure" serious and chronic mental illness. Effective treatment and care, however, enhance the functioning and quality of life for many with serious mental illness. Sufficient community-based services and social support alternatives to long-term hospitalization allow persons with serious mental illness to survive and often to live productive and satisfactory lives in the community.

Federal Policy

The transfer of patients from state hospitals to community settings was accelerated with the passage of the federal Community Mental Health Centers Construction Act in 1963. A majority of funds provided under this legislation were for the construction and staffing of the new community mental health system. Provision of essential services by community mental health centers supposedly would make this deinstitutionalization process possible by diverting individuals who otherwise might have been hospitalized. The number of residents in state mental hospitals has decreased from 560,000 in 1955 to 120,000 today.(10, p. 1)

The establishment of federal funding sources for persons with serious mental illness--Medicare, Medicaid, and SSI--stimulated state fiscal planners to transfer a large portion of strictly state costs to the federal government. As a result of the federal government's sharing at least 50 percent of care expenses, thousands of state hospital patients were "transinstitutionalized" to Medicaid-supported nursing homes. Because little mental health care was rendered in these facilities, nursing homes became inappropriate settings for many with serious mental illness.

In order to limit access to services and control costs, the federal Medicaid program has placed constraints on the mental health services eligible for coverage and, in general, has not financed services eligible for coverage and those designed as alternatives to institutional placements. In 1981, however, Congress passed a Home- and Community-Based Services waiver provision within Medicaid that allows a state to expand its covered services for certain targeted populations, provided the state could show that the cost of the waiver services would not exceed that of the institutional services they were replacing. These 2176 waivers frequently have been difficult for states to obtain, but they have allowed states to experiment with home- and community-based programs as service alternatives to institutional care.

In response to continued criticisms about the community mental health system, the federal government developed two major concepts. In 1977 the National Institute of Mental Health established the Community Support Program (CSP) in an attempt to address the critical needs of people with long-term mental illness. The program was intended to assist states and communities in developing systems of care that offer an array of services for people with serious mental illness. The CSP and Children and Adolescent Service System Program (CASSP) have provided small state grants over the past 10 years to develop model projects, but budgetary constraints have curtailed the programs in recent years.

The federal government has moved recently on several fronts to effect care for persons with mental illness, including:

- The Omnibus Budget Reconciliation Act of 1987 (Nursing Home Reform Act) mandated the diversion of psychiatric patients from nursing home admission and required states to remove many of those psychiatric patients currently residing in nursing homes to more appropriate settings. The emphasis by the federal government has been to require active treatment programs for both mentally ill and mentally retarded persons. The provisions of the Nursing Home Reform Act and increased federal efforts to require active treatment at state mental health institutes are expected to produce major new costs to states and local government and to create new demands for alternative services.

- The Stewart B. McKinney Homeless Assistance Act of 1987 provided both emergency and long-term approaches to housing homeless persons, including those suffering from mental illness.

- The Mental Health Planning Act of 1986 authorized state grants to develop and implement state comprehensive mental health plans for persons with severe and disabling mental illness.

- The Protection and Advocacy for Mentally Ill Individuals Act of 1986 expanded the role of existing statewide protection and advocacy programs to protect the rights of people with significant mental illness residing in facilities providing care and treatment.

- The Omnibus Reconciliation Act of 1986 and the Consolidated Omnibus Budget Reconciliation Act of 1985 made several changes to the Medicaid program that affected persons with mental illness, such as the inclusion of case management services and recognition of persons with chronic mental illness as a target population.

State Policy

Several states are attempting to address comprehensively the needs of those with serious mental illness.(1) California, Ohio, Rhode Island, Vermont, and Wisconsin are realizing that a fully developed continuum of care is needed to respond to the complex and diverse needs of this population. Such a continuum of care includes the following components: a range of inpatient and crisis stabilization services, vocational skill training and placement, daily living skill training, social and leisure activities, a spectrum of housing opportunities, medical and mental health care, case management, and a variety of support services.

California adopted the Children's Mental Health Services Act of 1987 to establish and coordinate a service system for children on a voluntary county basis throughout the state. The legislation was based on the effectiveness of a demonstration project, known as the Ventura County model, which produced a comprehensive services system for children, increased interagency collaboration, and enabled children to be served near home. The legislature expanded the Ventura County model to seriously mentally ill adults and seniors in 1988.

Ohio is restructuring its mental health system under legislation that passed in 1988. The new law provides for merging clinical and funding authority at the local level. A lump sum is to be allocated to each community board, including money to purchase inpatient care. The community boards are to buy back needed patient days from state hospitals. If the community boards are successful in decreasing hospitalization, additional money will be available to spend on community services. The boards, in turn, would be legally responsible for the care and treatment of each client.

Rhode Island ranks number one in the nation for its services to seriously mentally ill persons, according to the 1988 survey entitled *Care of the Seriously Mentally Ill: A Rating of State Programs*. Community mental health centers do a commendable job in focusing services on seriously mentally ill patients. These centers perform the admissions screening for the state hospital to expedite the client's discharge and coordinate care. The centers also coordinate housing, and the state's group homes are considered to be the nicest in the country. The state has a special financial supplement to families caring for seriously mentally ill family members at home.

Vermont is a long-time leader in shifting patients from the hospital to the community. The state has organized its community centers specifically to respond to the needs of patients released from the state hospital to prevent rehospitalization. Between 1981 and 1983, half of the state hospital's 300 patients were transferred from the state hospital to the community. This effort has been so successful, and the recidivism rate of these clients so low, that a legislative joint committee recently recommended phasing out the hospital for all but the forensic patients and those patients who are the most difficult to manage. Money saved from closing the hospital wards and renting the hospital for state office space will be used for additional community services. Medicaid will provide

additional funding, since 55 percent of state hospital patients would become eligible upon discharge, compared with 11 percent of inpatients who are currently eligible.

Wisconsin is considered a pioneer in its efforts to shift mental health resources from institutions to community care. The legislature transferred the responsibility for mental health services to counties in 1974. The statute required each county to provide a full range of inpatient and community mental health services. A Unified Services Board in each county was designated to administer all state and county mental health funds, and savings from reducing hospital care can be used to expand community services.

Most of these states have made significant use of federal provisions to expand their Medicaid program efforts. Vermont has used the 2176 Home- and Community-Based Services waiver program to return home approximately 100 emotionally disturbed children. Both Vermont and Wisconsin have provided targeted case management services under Medicaid to serve their mentally ill populations better.

In addition, to these options, other states have sought to expand Medicaid service definitions to cover a broader range of community-based services. Florida has been successful in receiving federal approval for covering rehabilitation services under its Medicaid program. Iowa and Kentucky have included day treatment services within their Title XIX state plans. Iowa also has included partial hospitalization services as well as case management. Several states have sought approval for respite care and behavior management services either through 2176 waivers or state plan amendments.

Oregon has gained increased federal support for its mentally ill population through aggressively seeking SSI eligibility for its clients and thus transferring some state responsibilities for care and support from the state to the federal government as well as expanding service availability. Oregon also has established a housing specialist within its social services agency to assist special populations (the mentally ill, mentally retarded, and developmentally disabled) find appropriate housing and to access federal housing monies for new housing developments. In addition to improving housing and service options, Oregon officials believe such efforts have resulted in savings to the state in the care and treatment of these populations.

Many states have attempted to improve mental health services or delivery systems by addressing specific service and delivery components, including residential programming, continuity of care, and case management and support services. Many states have enacted legislation to provide assistance or respite to families caring for mentally ill or mentally retarded relatives at home. Michigan has one of the largest of such programs, providing more than $8 million annually in support payments to families, which can be used to purchase respite care, special equipment, or basic support services. Family support programs are discussed more fully in the section entitled "Families Who Provide Care at Home to Children with Disabilities." Other states have acted to ensure coordination of mental health services or have improved the continuum of care between the hospital and community. A number of states have addressed the need for appropriate residential and other support services for those residing in the community.

Key Points

In examining the problems confronting mental health systems, the following key points should be considered in the development of sound public policy:

- Even though 77 percent of persons with serious mental illnesses are in the community, more than two-thirds of the funding goes to state mental hospitals.(4, p. 3)

- **The lack of community-based housing and support services has left the treatment of those experiencing serious mental illness to inadequate, inappropriate service systems. This lack of community resources has created a demand for institutional care.**

- **Services funded and administered by different levels of government and operated by the public and private sectors result in little continuity of care.**

- **Some persons with mental illness, such as children and those suffering from mental illness and substance abuse or mental retardation, do not fall clearly under the jurisdiction of one agency.**

- **Exclusionary zoning has banned small group homes from many residential neighborhoods and resulted in "social service ghettos."**

- **Making it easier to hospitalize through involuntary civil commitment can result in channeling more money to the state hospital and less to community care. Adequate community care, in turn, can reduce the need for hospitalization.**

- Between 18-25 percent of older persons have significant mental health symptoms.(8, p. 103)

- Of the nation's three million seriously mentally disturbed children, two-thirds are not receiving needed services.(3, p. ix) Approximately 50 to 80 percent of children and adolescents with serious mental illness retain their disability into adult life.

- Between 20 and 35 percent of jail inmates in large cities are mentally ill, many incarcerated on misdemeanor charges.(11, p. 1) Corrections officials calculate that 10 to 35 percent of state and federal prison inmates are seriously mentally ill.(7, p. 19)

- An estimated one-third of today's homeless population suffers from severe and disabling mental illness.(2, p. 7)

- Approximately one million patients suffering from chronic mental illness reside in nursing homes, many inappropriately placed.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative actions to address the major mental health system issues:

- Develop community alternatives to inpatient psychiatric care, such as community-based crisis programs.

- Implement outpatient involuntary commitment mandates to compel persons who need treatment to comply with less expensive and less restrictive community-based treatment orders.

- Develop comprehensive community-based care systems that provide safe, affordable housing; job training and employment; adequate outreach and follow-up services; and specialized services for children, the elderly, the homeless, and persons with a diagnosis of mental illness and substance abuse or mental retardation.

- Prevent restrictive zoning and similar exclusionary practices against group homes for those with mental illness.
- Implement housing programs that encourage stable, long-term living arrangements that are widely dispersed in neighborhoods and that minimize community opposition.
- Develop a single point of authority responsible for all mental health funds and service delivery.
- Broker care for clients moving between systems and services through the use of case managers, treatment teams, and liaison mechanisms.
- Develop special outreach programs to identify seriously mentally ill individuals eligible for, but not receiving, SSI, SSDI, and related benefits.
- Reorganize the delivery of services to expand federal participation under Medicaid to fund less restrictive community-based mental health services.
- Shift funds from state mental hospitals to community services through the development of services needed by discharged patients and the subsequent closure of hospital beds and positions.
- Provide financial assistance and respite care to families caring for relatives with mental illness at home.
- Expand the mandated mental health insurance coverage and review state health insurance coverage levels for possible revision with respect to inpatient and outpatient care and treatment of mental illness in order to provide more effective treatment.
- Develop risk pool coverage of mental health services for those individuals with serious mental illness who have trouble obtaining private insurance.
- Consider the issuance of bonds for financing capital improvements for state mental hospitals and other mental health facilities.
- Reuse surplus state mental hospital property through the rental or lease of empty buildings to new users or through land leased to private residential developers in exchange for financial or other incentives.
- Encourage entrepreneurship for community mental health centers to develop for-profit services or businesses to subsidize other programs.

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PEDIATRIC HIV INFECTION AND DISEASE

Commentary

AIDS (acquired immune deficiency syndrome) is rapidly emerging as a major health threat to large numbers of infants and young children. It is the ninth leading cause of death among children one to four years of age.(5, p. 8) If current trends continue, AIDS could be among the top five causes of childhood death by 1993.(5, p. 8)

Currently, there are more than 1,859 reported cases of children under 13 with AIDS.(3, p. 9) These reported cases are just the tip of the iceberg and do not reflect the number of infants and children who have no symptoms or suffer from earlier stages of human immunodeficiency virus (HIV) disease. The U.S. Public Health Service estimates that by 1991 there will be at least 10,000 to 20,000 HIV-infected children.(5, p. 18)

The rise in the number of pediatric AIDS cases is closely related to the dramatic increase in transmission of HIV among intravenous (IV) drug users who share needles. Eighty-one percent of pediatric AIDS patients contracted HIV infection through perinatal transmission, largely from a mother who was an IV drug user or the partner of an IV drug user.(3, p. 9) Since 1986 drug-related HIV disease has increased from 17.2 percent of reported cases to 22.2 percent of reported cases in 1989.(11, p. 5) The rate of infection among intravenous drug users will probably continue to have an effect on future rates of pediatric AIDS. (See the section entitled "Combatting Substance Abuse and Its Effect Upon Families.")

Pediatric HIV infection and disease differ greatly from AIDS in adults. Infants often experience severe bacterial infections and lung infections not seen in adults. Many children with HIV disease do not go through normal developmental milestones and also suffer from mental or motor retardation. HIV infection is difficult to diagnose early as children born to infected mothers can test positive for antibodies acquired from their mothers for as long as 15 months.(11, p. 95) Approximately one-third of infants born to HIV-infected women will develop HIV disease.(1, p. 1646)

Treatment for pediatric AIDS demands that child welfare, social services, and medical communities interact. Untreated infection is invariably fatal, and experimental therapies are the only recourse available at present. Yet, welfare agencies in many areas of the country have refused to allow HIV-infected children that are wards of the state to participate in medical or social research.

Pediatric AIDS takes its greatest toll on minority and disadvantaged children. While black children comprise 15 percent of the U.S. population, 53 percent of all pediatric AIDS cases are black.(11, p. 94) Hispanic children are 10 percent of the child population but 23 percent of the childhood AIDS population.(11, p. 94)

Children with HIV infection and disease are often born into families already afflicted by numerous social and medical problems--poverty, single-parent households, drug abuse, educational disadvantage, and poor access to health care. As a result, these children and families have a tremendous need for public services, such as health care, income maintenance, and foster care.

Often HIV-infected children are homeless. This may occur as a result of the mother being homeless, gravely ill and disabled, debilitated by drug abuse, or dead. Consequently, there is a critical need for foster homes for HIV-infected children. Sometimes a grandmother or other relative can

take care of the ill child, but often he or she is placed in a foster home. Because of the special needs of HIV-infected children and because of potential foster parents' fears about HIV transmission, foster placement is particularly difficult. HIV-infected infants often become "boarder babies" living out their lives in hospitals with only health professionals as families.

Lack of housing greatly contributes to higher costs of care for children than for other persons with AIDS. A recent study of pediatric cases at Harlem Hospital Center in New York indicated the average lifetime cost was over $90,000.(4, pp. 323-24) Some pediatric patients' lifetime costs were as high as $184,000.(4, pp. 323-24) The average hospital stay was four months for pediatric AIDS patients compared with 20 days for adult AIDS patients.(4, pp. 323-24) The study estimated that placement in other types of facilities could have saved 30 percent of the hospital days and 20 percent of the costs of care for these infants.

Care systems attempting to address the complex social and medical needs of children and families with HIV are more effective when they are comprehensive and integrated. Care systems offering comprehensive services have been proven to reduce the number of hospitalizations markedly and improve quality of life. Use of ambulatory care and community-based services by children with HIV infection helps reduce hospital length of stay and thereby costs of care.

Along with cost-effective care, prevention is of primary concern. Preventing the transmission of HIV to infants and children involves addressing adult behaviors. Unfortunately, the adults and adolescents of reproductive age who are at risk of transmitting HIV infection are mostly drug abusers and their sexual partners. These groups may be the most difficult to reach and the most resistant to behavioral change.

Testing, as a means of prevention, is very controversial. There are strong arguments in support of and against HIV testing of women of childbearing age. Supportive arguments include: Women may benefit from more rapid diagnosis of complications of HIV infection; women and children may benefit by allowing therapy to be initiated more rapidly; and women may be able to take measures to prevent pregnancy and transmission to sexual partners. Arguments against testing include: Women will avoid medical care, prenatal care, and hospital delivery; and a positive test may result in discrimination, which could involve loss of job, housing, social contacts, and resources for children.

Federal Policy

Until recently, the federal government's efforts on AIDS have been criticized for being underfunded, uncoordinated, and insufficient.(8, p. 10) Little attention was targeted on AIDS prevention and treatment for children prior to 1988.

On June 24, 1988, the Presidential Commission on the Human Immunodeficiency Virus Epidemic submitted a final report to the president. A number of recommendations pertained to infants and children with AIDS in the areas of funding, patient care, research and treatment, testing, outreach, and provision of social services.(6, pp. 1701-34)

The Infants Assistance Act of 1988 authorizes $37 million for the secretary of Health and Human Services to fund demonstration projects of public and private nonprofit entities. Projects to be funded include those that would help prevent the abandonment of HIV-infected infants and small children; and those that identify, address, and meet the needs of this population and their families. The act also authorizes the secretary of Health and Human Services to conduct a study to estimate the number of infants abandoned in hospitals and the number of those infants who have AIDS.

Overall, the effectiveness of the Infants Assistance Act is questionable, as money has been authorized but not appropriated in the federal budget.

The Medicare Catastrophic Coverage Act of 1988 will give states more ability to provide comprehensive and special care to HIV-infected children. This act allows states to apply for waivers to develop individualized, community-based services for infants and young children that will be paid by states' Medicaid programs.

State Policy

Most states are just beginning to develop policies and plans for their pediatric HIV-infected population. Yet, pediatric AIDS is not confined to a few select states. Thus far, 46 states and the District of Columbia have reported cases of children with AIDS.(3, p. 5) The states with the largest number of cases (150 or more) include California, Florida, New Jersey, and New York. The second cluster group, comprising more than 30 cases, includes Connecticut, Georgia, Illinois, Maryland, Massachusetts, Pennsylvania, Texas, and Puerto Rico.(3, p. 5)

Many comprehensive care systems have been developed at the local level. Providers and care systems in major cities in Florida, New Jersey, and New York have developed specialized medical and social programs with emphasis on case management and community-based outpatient care. For instance, New York City's Human Resources Administration has developed the Family and Children's Case Management Program. It is designed to enable the household affected by AIDS to remain together as long as possible. The program offers a wide array of specialized counseling and medical services, as well as referrals for foster care services. Family AIDS case managers are given fewer families than other social workers in order to meet the needs of multiple family members with AIDS. Where special services are not available, states will play an important role in developing pediatric AIDS programs.

Financing alternative care to hospitalization is emerging as a state concern. Many states are considering or are developing Medicaid waiver programs to allow for comprehensive and community-based services for HIV-infected children.

- *Connecticut*--The Medicaid program is drafting a waiver for "intensive supervision of children with AIDS." The waiver would transfer to Medicaid the cost of the supplemental payment, an additional $600 per month above the normal foster care allowance, to provide for respite care and other special services.

- *Maryland*--Pediatric AIDS cases are eligible for coverage under Title XIX coverage for disabled children.

- *New Jersey*--Through a Medicaid waiver, home- and community-based services are targeted to the large number of drug-using adults with AIDS and their infected children. The clients are case-managed and are provided with medical and psychosocial care and drug abuse treatment in the home. The waiver also provides for increased reimbursement for foster parents of children with HIV infection and disease. Private and public entities, including the New Jersey Division of Youth and Family Services, have combined resources to operate a noninstitutional group home for infants and children with AIDS. It serves as a transition from the hospital to a foster home.

Key Points

In developing policies for pediatric HIV infection and disease, the following points merit consideration:

- HIV disease is gaining momentum as a threat to the lives of infants and children.

- Nearly 80 percent of pediatric AIDS patients contracted HIV infection from a mother with or at risk of AIDS/HIV infection.
- Close to 60 percent of pediatric AIDS patients contracted HIV from a mother who was an IV drug user or a partner of an IV drug user.
- Pediatric HIV disease differs from the disease in adults, both medically and socially.
- There is an increasing need for the medical and social services communities to interact to facilitate effective and humane care.
- Minority and impoverished communities are afflicted with a disproportionate share of pediatric AIDS cases.
- There is a large need for foster homes for children with HIV infection and disease.
- Costs of care are much higher for pediatric AIDS patients than for adult AIDS patients.
- Adults who are at risk of transmitting HIV infection to children are difficult to reach.
- Testing as a means of prevention is controversial.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state action for sound public policy on pediatric HIV infection and disease:

- States should have access to a substantive data base of HIV infection information and a health statistician to help make informed decisions on behalf of children in the state's care.
- States should ensure that HIV-infected children who are wards of the state have access to palliative and possibly curative clinical trials and treatment, with all the protection given to any child.
- States should confront the possibility that alternative residential care may be needed at some time for some HIV-infected children. Promising models of care should be explored jointly with state and local welfare officials and health authorities.
- State and local social services agencies should establish a special HIV unit to develop comprehensive care programs for biological and foster families with HIV-infected children.
- States should recognize grandmothers and other relatives of children with HIV infection as an appropriate source of foster care. Relatives should be made eligible for foster care stipends.
- State child welfare agencies should consider ways to facilitate and accelerate the certification and licensing of potential foster parents for HIV-infected children, particularly when these individuals are relatives.

- States should develop incentives to encourage foster care of children with HIV infection such as an increased foster care stipend and access to daycare and respite care.
- State Medicaid agencies should apply for and use any available waivers to assure coverage of in-home and community-based services needed by children with HIV infection and disease.
- States should consider developing optional case management services, tailored to meet the special needs of children with HIV infection and disease, in cooperation with the state's Maternal and Child Health program.
- States and local authorities should expand the availability and use of voluntary HIV counseling and testing.
- States should take advantage of allowable state plan options to make it easier for medically impaired families to apply for financial and social services.
- States should provide HIV prevention programs and information in locations frequented by hard-to-reach groups.

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ACCESS TO FAMILY HEALTH CARE: THE MEDICALLY INDIGENT

Commentary

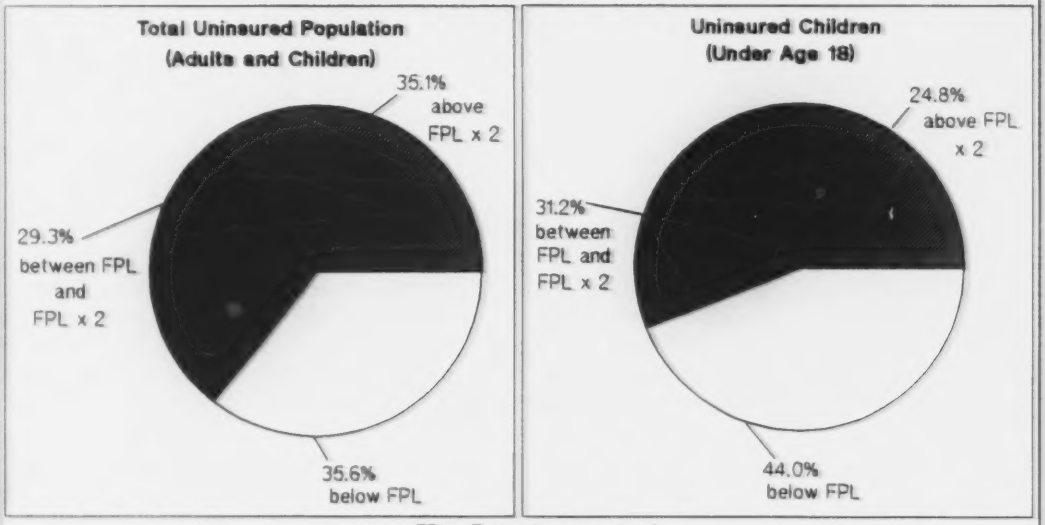
The medically indigent are low-income (often young) people who are unable to pay for health care support through public or private insurance. Many Americans have inadequate health insurance to cover all health care costs, and an estimated 36.8 million have no health insurance at all. This is a substantial portion of the nation's population, equaling the combined populations of 24 states. A vast majority of uninsured people do not have access to group insurance and cannot afford to purchase insurance on their own.

Some of the increase in the uninsured population is due to the smaller percentage of persons below the FPL who are covered by Medicaid. Another contributing factor is the national move toward a "service economy," where employees are less likely to be covered for health insurance. Fewer employees work in unionized manufacturing industries, which traditionally offer good health insurance benefits.

A 1987 survey reveals the following about the 36.8 million uninsured Americans:(17)

- Half are under age 25; 31 percent are under age 19.
- Almost 80 percent are employed at least part time or are the dependents of employed persons.

Figure 7.
Uninsured Population by Family Income

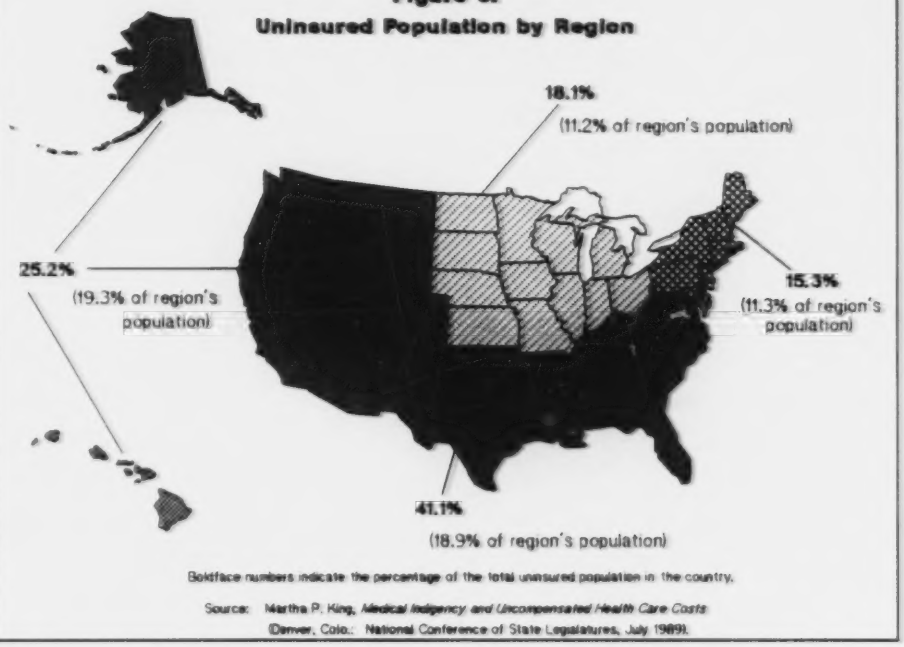

Total Uninsured Population
(Adults and Children)
35.1% above FPL x 2
29.3% between FPL and FPL x 2
35.6% below FPL
Uninsured Children
(Under Age 18)
24.8% above FPL x 2
31.2% between FPL and FPL x 2
44.0% below FPL

FPL: Federal poverty level.

Source: Martha P. King, *Medical Indigency and Uncompensated Health Care Costs* (Denver, Colo.: National Conference of State Legislatures, July 1989).

- More than one-third have family incomes below the FPL, and 44 percent of all uninsured children live in such families.
- More than 78 percent of the uninsured population are white; but almost one-third of all Hispanics and 22 percent of all blacks are uninsured.
- A greater proportion of the uninsured population live in the western and southern regions of the country.

Figure 8.
Uninsured Population by Region



Boldface numbers indicate the percentage of the total uninsured population in the country.

Source: Martha P. King, *Medical Indigency and Uncompensated Health Care Costs* (Denver, Colo.: National Conference of State Legislatures, July 1989).

Uninsured persons under age 65 can be divided into several categories, including the following:

- *The Employed Uninsured.* Almost one-third of uninsured employees work for employers who do not offer insurance.(6, p. 5) Small firms are less likely to offer health benefits than large ones. In 1987, 26 percent of employees in firms with fewer than 10 employees had no health insurance, accounting for one-third of the total uninsured population. Many small businesses do not qualify for group insurance rates and cannot afford to provide individual policies for their employees. More than one-third of uninsured workers do not participate in their employer's health insurance plan even though they are eligible.(6, p. 5) The cost of the employee's share of the premium may be an obstacle for many, especially for dependent coverage. Approximately one-third of uninsured workers do not qualify for their employer's health plan.(6, p. 8) For example, many part-time and temporary employees are ineligible for an existing plan. Also, insurance companies often exclude employees who work in hazardous jobs.

- *The Unemployed Uninsured.* In 1987 an estimated 21.7 percent of uninsured persons were out of the workforce.(15) Data from 1984 revealed the following about nonworking, uninsured adults, aged 18 to 64: Almost one-half were homemakers, including divorced or widowed persons; nearly one-third were unable to work or were retired; and almost one-quarter were students.

- *The Underinsured.* Underinsured persons are those who cannot pay for medical care not covered by their insurance. In some cases, this means deductible costs or copayments. In other cases, it means procedures or expenses not covered by an insurance policy, such as a liver transplant. High unpaid medical bills are often referred to as "catastrophic" expenses. Nearly every health care consumer has the potential of facing a catastrophic expense because insurance policies generally have a cap on expenditures.

- *The Uninsurable or "High-Risk" Population.* This group consists of persons with high health risks, such as heart disease or AIDS, who are refused health insurance coverage. In some cases, high-risk persons would be eligible to purchase an individual policy at a much higher premium but cannot afford it.

- *Others.* Some uncompensated hospital care is generated by persons who presumably can pay for their care but do not. Many of the unpaid bills are from persons who have insurance but do not pay their deductible or copayment amount. It is unclear how many insured persons have difficulty paying these costs.

Medical indigency is the number one health issue on state legislative agendas. Uncompensated care cost the states almost $12 billion in 1987. The following facts exemplify tough questions that legislators are attempting to address:

- Rising health care costs and growing state fiscal pressures have forced states to cut back on increases in Medicaid program expenditures, partly by limiting eligibility. In 1975 approximately 63 percent of persons with incomes below the federal poverty level qualified for Medicaid; by 1986, the number dropped to 41 percent.

- State governments and health care providers are faced with increasing health care costs for medically indigent persons at the same time that resources are shrinking. In 1987 state and local governments paid for approximately $1.6 billion of the nation's total uncompensated hospital costs, which left $7.2 billion to be subsidized by private payers and hospitals.

- In the past, hospitals passed along the costs of uncompensated care mainly to insured and private pay patients. Competition among hospitals and changes in reimbursement practices, such as prospective payment and group contracts, have limited this "cost-shifting" practice.

- Instead of treating uncompensated care patients, many hospitals are transferring patients who cannot pay for care to hospitals that will accept them. This practice has increased the burden on public hospitals.

- The shifting of the uncompensated care burden to insured patients and the spiraling costs of employee health insurance plans have led businesses to become actively involved in lobbying for legislative changes in the health care system. In addition, businesses are cutting their costs by negotiating with providers for reduced rates through "preferred provider" contracts and by reducing unnecessary hospital use by employees. These measures limit the private sector's contribution to uncompensated care costs through cost shifting.

- The burden of uncompensated care falls heavily on public and teaching hospitals. Already subsidized heavily by government, these hospitals are finding it increasingly difficult to bear the increased costs and may require additional assistance. These hospitals are actively pressing legislatures to assist them with this burden.

- Uninsured persons are less likely than the insured to seek needed medical care. Lack of primary and preventive care can lead to more costly care in the future. For example, maternity and newborn care accounts for about 27 percent of unpaid hospital bills. Many uninsured pregnant women do not receive adequate prenatal care, which greatly increases the risk for complications, including low birthweight babies. (See the section entitled "Prevention of Low Birthweight in Newborn Babies.")

Federal Policy

The federal government does not sponsor a program specifically for "medically indigent" persons, nor does it appropriate money to state or local governments or health care providers to cover uncompensated health care costs specifically. Health care services for low-income uninsured people is a state responsibility, although Medicaid expansion offers an opportunity for federal and state governments to share future indigent care costs and coverage of target groups.

State Policy

State efforts to ensure access to health care often have been stymied by the huge cost of providing basic medical services to those who cannot afford them. However, the concerns of medically indigent individuals, health care providers, and businesses have sparked increased legislative interest. Recent legislative actions have resulted in a range of approaches to providing basic health care to all Americans, including new financing mechanisms, programs targeted at specific medically indigent groups, and proposals and pilot projects to provide insurance coverage to more residents. Many of these approaches are new and their effectiveness untested, but these unique innovations are the building blocks for future state efforts in this area.

- In April 1988, Massachusetts enacted the first legislation designed to guarantee health insurance to all 600,000 of the state's uninsured residents. The law is designed to expand the number of businesses providing insurance to their employees. Other uninsured persons would receive insurance through a state program administered by the new Department of Medical Security. The program is funded by an employer surcharge and premiums paid by uninsured persons on a sliding fee basis.

  By 1992 businesses with more than five employees will be required to pay a surcharge into a health insurance trust fund of 12 percent on each full-time employee's first $14,000 in wages, up to a maximum of $1,680 per employee. Employers who provide health insurance can deduct those costs from the surcharge.

  The law provides incentives for small businesses to provide insurance before the 1992 deadline. These include technical assistance to brokers for small business insurance, an insurance pool to provide group rates for businesses with fewer than five employees, and a new tax credit for total premium expenditures.

- The Washington Legislature created the Washington Basic Health Plan, considered by many to be the most innovative uncompensated care program of 1987. The plan establishes five regional pilot programs that offer health insurance through managed care systems. Managed care systems are organizations of providers that deliver or contract for

a schedule of basic services, as defined by the state administrator. A maximum of 30,000 individuals with incomes below 200 percent of the poverty level may be enrolled.

- New Jersey operates the Uncompensated Care Trust Fund through its hospital rate-setting system. As modified in 1987, each hospital adds a uniform percent charge to patient bills to fund uncompensated hospital care. In 1989 this rate was 10 percent and generated about $500 million. The trust fund redistributes funds from hospitals that provide less uncompensated care to those that provide more than the add-on rate. The system is intended to provide more equitable price competition among hospitals that provide widely divergent amounts of uncompensated care.(11, p. 5)

- The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, created a program with the Robert Wood Johnson Foundation to provide affordable health insurance to small businesses. A local survey found that 43 percent of small businesses do not offer insurance. Many small businesses are unable to obtain group rates because they have too few employees or because they are in an industry considered too risky.

  The new program is known as the Health Care Group of Arizona (HCG). Employers with 25 or fewer employees who have not offered group insurance in the last six months may participate if at least half of their employees enroll. Employers may select among four HCG benefit packages. One option provides only catastrophic coverage over $2,000; another option offers extensive coverage such as health maintenance organizations (HMOs). A third option covers hospital services, but participants pay 20 percent of charges. The final option pays all hospital inpatient and outpatient charges up to $20,000; participants must pay charges above this level.

- Florida operates several programs to provide care to the medically indigent. A 1984 law established a 1.5 percent assessment on hospital general revenues to fund expansion of the state Medicaid program. Medicaid expansion was not as costly as estimated, and the Public Medical Assistance Trust Fund ran a large surplus. Hospital dissatisfaction with the assessment surplus was addressed in 1987, when a formula to redistribute the surplus was developed to target health care providers offering substantial charity care.

  In 1987 the Florida Legislature established the Small Business Health Access Corporation to provide group health insurance rates by pooling small businesses into a large group. The state appropriated $500,000 to operate the corporation and defray development costs such as market research, design, and promotional materials.

- The Wisconsin Legislature established three pilot programs in 1988 to expand insurance availability through employers and to individuals who have difficulty qualifying for private insurance. A summary of the three programs follows:

  * The Subsidy for Low-Income Employees of Non-Insuring Firms will encourage businesses that do not offer insurance to start group programs. Employees of participating businesses will receive vouchers redeemable only through their employer. Assisted by a grant from the Robert Wood Johnson Foundation, technical advice on designing benefit plans and obtaining low-cost insurance will be provided by the state.

  * The Subsidy for Low-Income Employees of Insuring Firms will assist employed, low-income people who cannot afford their share of the employer's group health plan. Health insurance will be subsidized based on a

sliding fee scale for 400 residents with incomes below 175 percent of the poverty level.

- The Alternative Health Care Coverage Pilot Project will allow up to 400 individuals who have difficulty qualifying for health insurance to buy into the state Medicaid program. Premiums will be based on a sliding fee scale. The pilot will be a less expensive alternative to the state's high-risk insurance pool.

- The Oregon Health Initiative of 1989 is intended to define the state's responsibility for providing health care for its citizens. The legislation calls for a public policy definition of the socially acceptable minimum level of care to which everyone should have access. The state's Medicaid program would be replaced with a new program to guarantee access to all low-income persons for specific priority health services. Health care service priorities are to be established by a Health Services Commission with public input. The plan, which requires a federal Medicaid waiver, would cover an estimated 77,000 more people than the existing Medicaid program. Covered benefits under the new program would be determined by the established priorities. If the program is trimmed in response to budget problems, the lowest ranked services would be eliminated, but persons covered would not lose eligibility.

- At least 15 states have insurance risk share pools to help provide access to insurance for high-risk individuals who otherwise would have trouble obtaining coverage. States with risk pools include Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, Tennessee, Washington, and Wisconsin. The costs to risk pool participants are usually 25 to 50 percent higher than the premiums paid by persons with private insurance. Even with the high contributions paid by covered persons, risk pool programs must be subsidized to cover their costs.

More doctors have agreed to accept assignment for Medicare cases in 1989. Congress established this program in 1984 to encourage doctors to halt balance billing of beneficiaries. Doctors are given incentives to join, including a 5 percent fee increase and simpler billing and payment rules. The federal Health Care Financing Administration provides lists of participating physicians to beneficiaries and consumer groups. Participation rates range from 78 percent in Alabama to 16 percent in Idaho. In 1989, 44 states experienced an increase in the number of participating physicians.(13, p. 1)

Rhode Island passed legislation in 1989 creating a Medicare assignment policy that eliminates age and income restrictions for Medicare beneficiaries and requires physicians to accept Medicare reimbursements as full payment. Previously, only individuals older than 65 and earning less than $12,000 per year were eligible.(14, p. 2)

This is not Rhode Island's first innovation in providing care to the uninsured or underinsured. The Rhode Island Catastrophic Health Insurance Plan (CHIP) was created to ensure that state residents receive medical services at reasonable costs that are not covered by private insurance, Medicare, or Medicaid. *Catastrophic* is defined in terms of the financial loss to a family, rather than by diagnosis. Eligibility is based upon the quality of the applicant's insurance coverage. The more comprehensive the insurance coverage, the sooner CHIP will help.

Another innovative program is the Connecticut Medicare Assignment Program, created in 1987. This program is administered by the Connecticut State Medical Society under contract with the Department on Aging, to issue a "medical courtesy card" that, when presented to physicians who agree to participate in the program, guarantees that they will accept Medicare's reasonable charge as payment in full. The department is required to adopt regulations making Medicare assignment

mandatory for all eligible physicians, if certain minimum physician and elderly participation levels are not met quarterly.

Key Points

As legislatures continue to address the concerns of the medically indigent population, the following key points should be considered when determining public policy strategies:

- Medically indigent persons face major access barriers to obtaining health care. They are not covered by public assistance and cannot afford necessary medical care provided through private insurance.
- Insured persons have much greater access to needed health care than the uninsured.
- Publicly owned facilities provide a disproportionate share of uncompensated care. Urban public hospitals represent about 5 percent of the hospital beds in the country but provide an estimated 40 percent of all charity care.(7)
- Employers have reduced the level of health care coverage provided to employees in response to the growth in health care costs. As a result of a service-based economy, jobs offer lower pay and fewer benefits. Some employees, particularly low-wage workers, have chosen to increase their take-home pay rather than purchase health insurance.
- Participation in public programs requires a better informed population, enhanced program eligibility and outreach, and increased provider participation.

Recommendations for State Action

The NCSL Children, Families and Social Services Committee recommends the following state legislative action to address the issue of medical indigency and uncompensated care:

- Identify who the uninsured persons are in individual states.
- Address the access problems for persons who need primary and preventive care.
- Address the inequities among hospitals that provide a disproportionate share of uncompensated care.
- Establish assistance programs to enable more of the working poor to purchase health insurance.
- Encourage small businesses to offer health insurance to employees through multiple-employer groups or tax incentives.
- Expand Medicaid eligibility to take advantage of federal matching funds, which range from 50 percent to almost 80 percent of medical assistance costs.
- Encourage or mandate insurance coverage for preventive and well-baby pediatric care.

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FAMILIES WHO PROVIDE CARE AT HOME TO CHILDREN WITH DISABILITIES: SUPPORTING THEIR EFFORTS

Commentary

The birth of a child with a severe disability or chronic illness often creates a crisis for the family and all involved. Though not a frequent occurrence, numerous children in the United States have disabilities or illnesses severe enough to prompt concern for their welfare and that of their families.

Families who provide care at home must learn how to implement specialized care routines while attending to normal family functions. Because of the added pressure, these families can face a variety of challenges over and above the normal responsibilities associated with bringing up a child. These potential challenges pertain to the entire family unit as well as the disabled member.

Available research suggests that the difficulties actually experienced by individual families are related to multiple factors, including the seriousness of the family member's disability, the presence of challenging behavior, family characteristics, specific parenting patterns, the family's capacity for coping with adversity, and the availability of community support services. As a result, though not all families who provide care at home have extraordinary problems, all are more at risk for having difficulties than families without disabled members.

Though providing care at home to a child with disabilities can be a challenging task, most families reject out-of-home alternatives in favor of continued care at home, especially during the early stages of the child's life. The recognition that many persons with disabilities live at home with their families prompts concern for assuring the delivery of needed services and support to family efforts. For policymakers, once a commitment is made to family-based care, this concern often is translated into the following questions: *What types and amounts of family-related services should be offered? How should they be administered?*

An effective response to family needs requires that a comprehensive and flexible array of supports be made available. Further, there is growing consensus that those supports offered should be well coordinated, family centered, culturally sensitive, community based, and integrated within existing community networks.

Federal Policy

Much of the social legislation passed since the mid-1930s was promoted on the premise that it would benefit families. Examples include: AFDC; Medicaid (Title XIX of the Social Security Act); Medicare (Title XVIII of the Social Security Act), food stamps, and WIC.

The current framework of services for persons with disabilities and their families stems largely from federal laws passed in the 1970s. During this period, major legislation was passed in a variety of areas on behalf of persons with disabilities. The laws reflected an emerging national consensus that persons with disabilities ought to receive needed supports within their local communities.

The principles established in these earlier laws have expanded in the 1980s. In this decade, however, discussion has focused less on whether persons with disabilities ought to be served and more

on what constitutes best practice given varying levels of disability and scarce resources. Services currently available to persons with disabilities include:

- *Income Maintenance*. The SSI program provides a base federal income support level for blind, disabled, or elderly persons. Eligibility is limited to individuals who acquire a disability before age 22 and who are not capable of "substantial gainful employment." Children under 18 years of age who are living at home, parental income, and other resources are taken into account, and only children of very low-income families qualify. The SSDI program provides payments to children with disabilities, aged 18 years or older, of retired, deceased, or disabled workers. Children under 18, whether disabled or not, are eligible for payments under the SSDI program provided that a parent who is retired, disabled, or deceased participated in the Social Security taxation program.

- *Health Services*. The major health care program for persons with disabilities is funded through Medicaid (Title XIX of the Social Security Act). Certain services, however, also are made available to children with health- or disability-related special needs through MCH Block Grants to states. The Medicaid program provides medical aid for "categorically needy" persons who were receiving public assistance and other medically needy persons. For children with developmental disabilities under 18 years of age, parental income is taken into consideration and is counted as an available resource. This situation creates severe hardship for many families of children with serious health problems who wish their children to live at home, but whose income makes their children ineligible for Medicaid coverage. To many, the policy actually encourages out-of-home placement.

  In 1982 the federal government granted states the option to provide Medicaid support for home care of children who otherwise would be served in an institutional setting at an equal or higher cost. However, as of 1988, only 12 states had taken advantage of this waiver. Additionally, states may opt to offer Medicaid services to children living at home without considering family income by modifying the state's Medicaid plan in accordance with the Tax Equity and Fiscal Responsibility Act passed in 1982. Again, relatively few states have taken this route.

  Programs offered through the MCH Block Grants were established through the Omnibus Budget Reconciliation Act, which enables states to develop systems to ensure that children with special health care needs have access to primary health care services.

- *Education*. Passage of the Education for All Handicapped Children Act of 1975 (P.L. 94-142) guaranteed all children with handicaps in the United States, no matter how severe their disabilities, a free and appropriate public education. This law pertains to children from ages three to 21 years. The expansion of this law through P.L. 94-457 in 1986 addressed services for infants and toddlers. The Infants and Toddlers Program requires that an individualized family service plan be provided for each child and family served. As of January 1988, all states had agreed to participate in these programs. P.L. 94-142 and its amendments provide for some federal funding to assist the states in meeting the costs of implementation.

- *Developmental Disabilities Services*. The Developmental Disabilities Act provides monies to fund Developmental Disabilities Planning Councils and protection and advocacy services in each state and a network of university-affiliated programs across the country. Additionally, funds may be used to pay for services such as case management, community living, and advocacy for this population. Family support services could be funded under the 1978 amendments. The 1984 amendments to the Developmental Disabilities Act focused on helping persons with developmental disabilities achieve maximum

independence, productivity, and integration into the community. In addition, employment-related activities became a priority under this amendment.

- *Residential Services*. The Social Security Amendments of 1971 authorized the costs of services in institutional settings to be paid by Medicaid. This law shifted fiscal responsibility for the operation of institutional programs from states to the federal government; strengthened the federal government's role in establishing standards for care in institutional settings; and allowed for the support of small, community-based intermediate care facilities for the mentally retarded. States may apply for waivers to establish a community-based service system more in keeping with emerging best practice. Other residential options include small community residences and foster home placement, with many states providing special training, support services, and a higher rate of payment to these foster care providers.

- *Vocational Services*. The Civilian Vocational Rehabilitation Act provided for the vocational rehabilitation of persons disabled in any legitimate occupation and their return to civilian employment. Since then, various complementing legislative acts have been executed, with a gradual strengthening of government's commitment to persons with disabilities. These laws provide grants to state vocational services and programs.

State Policy

Most family support in the United States is still provided through informal, personal support systems made up of relatives, friends, neighbors, and acquaintances from community organizations. However, these informal systems may be insufficient in assisting a family that has a disabled child. In addition, the natural support networks of some families may be very weak.

Over the past 10 years, all states have taken steps to establish programs to support family efforts. The definition of family support services varies. Services most commonly offered are case management, respite care, parent education, home adaptations, special equipment, and transportation. Other services may include information and referral, parent/family counseling and peer support groups, homemaker services, attendant care, chore services, in-home nursing services, future planning, and cash assistance.

In general, these programs utilize either an exclusive support services approach or provide cash assistance with support services. In a support service program, a state contracts with a third-party agency to provide services to families. This approach may be least responsive to the needs of families because:

1) Service agencies may not offer all needed supports;

2) Systems may not be sufficiently flexible to accommodate unique family needs; and

3) Families are not empowered to choose the service provider.

By contrast, in a cash assistance program, the funder provides dollar resources directly to families, who in turn select and pay the support agent of their choice. At least 22 states now haveinitiated a cash assistance program, although most are rather modest in scope. Restrictions may be placed on the types of expenses to which the cash may be applied, and family members may need to show receipts to document how the cash was spent. This approach can empower families and encourage service providers to be accountable to family members directly. However, services may not be available to purchase, family members may not have sufficient information for making informed choices, and some families may not wish to play such an empowered role.

Combination programs can be used to offset the disadvantages and build on the strengths of a support or cash assistance strategy. Funds may be provided either directly to families or to service agencies, depending on the type of support needed, family preferences, or other factors. This approach encourages families and professionals to be active and cooperative participants in the service delivery process. Further, while embracing aspects of a support service approach, it ensures that family members have some amount of cash on hand to accommodate unique needs and enhance family functioning.

Wisconsin started the Family Support Program in 1983 to help ordinary families faced with the extraordinary challenge of caring for a child with severe disabilities. The program assists parents in locating needed public and private resources and providing funds to buy those things that the family needs but cannot get through other sources. The state has found that direct assistance to families is not only more cost-effective than out-of-home placement, but it is more beneficial to the child and family.

Michigan has a goal of returning all children from state institutions to the community. In 1989 fewer than 50 children remained in state centers. The institutional system has been replaced by residential community programs delivering services to more than 10,000 persons with developmental disabilities. This system provides an array of options, including family supports; subsidy programs; adoption programs for abandoned, handicapped children; and various levels of specialized foster care intervention, group homes, and semi-independent living arrangements. Supports that help disabled children in the home include cash subsidies and respite services.

Michigan pays direct cash subsidies of approximately $243 per month to families with children who have a severe disability. The subsidy helps defray care-related costs, such as specialized equipment, respite care, and home renovation. To qualify for the subsidy, a family must earn less than $60,000 and have a severely disabled child under age 18. After that age, the disabled person becomes eligible for SSI. The average cost of the subsidy program per child per day is $7.50, a cost far less than what might be incurred by a state institution or community residence.

However, most existing state programs are rather limited in scope and are vulnerable to shifting political priorities. Except for Michigan and Wisconsin, these programs generally offer limited services to few families, place restrictions on the types of supports offered, fail to utilize existing community networks, and are slow to empower family members.

Further, programs funded primarily with state dollars are expensive to operate compared with initiatives that have federal matching funds, such as Medicaid. Consequently, fiscal and programmatic resources allotted to these programs are far less than expenditures for out-of-home alternatives. Family support programs can be difficult to initiate, expand, or maintain, especially when state funds are scarce.

Key Points

In examining families who provide care at home to children with disabilities, the following points need to be considered:

- Families with disabled members can benefit from at-home care, which enhances their capacity to provide care and improves the quality of life.

- With sufficient services, some families will not need alternative placement for their disabled member or may be able to have their member return home.

- Strengthening the family structure may create cost savings for the state as a result of a diminished need to fund expensive alternative residential options.

- Because no two persons with developmental disabilities or no two families are alike, responsive family support programs must make available to families a wide array of support systems and encourage each family to select those services that are most appropriate to meet its needs.

- Support systems must be available to families from the onset of disability until the disabled person leaves the natural home.

- Eligibility criteria for family support systems should pay particular attention to families with disabled persons under 22 years of age and to families providing care to persons whose needs pose an extraordinary challenge to the family.

- The public sector cannot be counted on to meet all family needs. Informal community networks, employers, and private health insurance carriers also should be called on to provide support.

- Because family care may end, residential alternatives to the family are needed.

- Disabled children can benefit from training in independent living and work skills to enable them to live in the community once they become adults or family care ends.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to implement family support programs:

- Adopt a clear set of guidelines for the development of support systems for persons with developmental disabilities and their families, such as:

  * All children, regardless of disability, have the right to grow up with a family, biological or otherwise, and need enduring relationships with adults.

  * The role families play in providing care at home must be recognized and nurtured so that family members are enabled and empowered to make informed decisions.

  * Means for supporting family efforts must build on existing support networks and natural sources of support within the community.

- Fund and implement family support programs for those families who provide care at home to their children with developmental disabilities.

- Coordinate all family-related activities undertaken by state agencies, e.g., Departments of Education, Human Resources, Public Welfare, and Mental Health.

- Make use of all public and private sector resources on behalf of families, including government agencies, private employers, and private health insurers.

- Evaluate any program enacted and establish clear accountability.

- Ensure adequate training for persons providing family supports.

- Ensure that all family support initiatives are designed to promote the integration of disabled persons into the community.
- Provide flexible programs to meet individual needs of disabled persons and their families.
- Provide independent living and work training to disabled children to facilitate transition into adulthood and to promote independence if family care ends.

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STATE INNOVATIONS IN CHILDREN'S AND FAMILY SERVICES COLLABORATION AND FINANCING

Commentary

Each family in society is unique and, at times, may require different types of support. Over the last 30 years, a wide variety of programs, services, and helping professions have been developed to assist families with different needs and to further understanding of specialized individual and family problems. This specialization also has tended to fragment service delivery, to set up professional walls between service workers, and to create a variety of separate program eligibility criteria and funding streams for services that are not integrated with one another.

Families, however, do not necessarily fit into specific service categories. Family needs often are multiple and interdependent. Failure to meet the needs of a family in one area often exacerbates its needs in another. Poor health can contribute to welfare dependency; school failure can lead to teenage pregnancy; substance abuse can contribute to child abuse; unemployment can lead to a sense of hopelessness and suicide; homelessness can exacerbate mental health disorders; poverty, and especially persistent poverty, can contribute to many other social service needs.

This interdependence and the need for interdependent solutions to family concerns are coming into much greater public focus. State lawmakers, aware of specific program expenditures in programs such as AFDC, Medicaid, substance abuse treatment, juvenile delinquency, foster care, and job training, are beginning to ask what the costs are of helping individual families and to seek ways to allocate funds better to meet those families' needs. A major challenge for states is to coordinate and restructure service delivery so that the appropriate needs of families can be met.

Every state has families that use many services. A welfare family, with the mother in mental health counseling, may have a youngest child in temporary foster care, a second child in special education, a third awaiting adjudication as a delinquent, and a fourth dropping out of school and likely to become pregnant. Five workers, each unaware of the other, may be actively involved with one or another family member and may send conflicting signals to the family. The overall state bill for the family may exceed $30,000 annually. Still, the family may not be receiving needed assistance to become more functional and self-sufficient.

In her book, *Within Our Reach*, Lisbeth Schorr identifies a number of risk factors--teenage parenting, welfare dependency, unemployment, single parenting, health problems, absence of parental support, persistent poverty--that can help produce "rotten outcomes" for children, such as unwanted adolescent pregnancies, school failure, delinquency, mental illness, and the reproduction of risk factors in their own children. She found that, when these risk factors appear together in the same family, the chances for rotten outcomes increase dramatically. Further, she found that these risk factors are more likely to appear together in communities characterized by the absence of economic opportunity.(5, pp. 23-32)

Schorr's book highlights a number of programs that have succeeded in addressing these risk factors and reducing the attendant rotten outcomes. One of the common characteristics of these programs is their willingness to cross agency and professional boundaries in providing support for families and to treat a family's needs and support its capacities for self-sufficiency regardless of categorical funding streams or professional service boundaries. The most successful interventions

started with the family's basic needs and worked outward from those needs to find the appropriate resources.(5, pp. 284-290)

In their book, *Toward a More Perfect Union*, Gordon Berlin and Andrew Sum outline the critical societal need for all children to acquire basic skills as a preparation for the adult workforce. While development of such basic skills generally is considered the responsibility of the school system, Berlin and Sum found that a focus on the school alone was unlikely to improve the skill attainment level of disadvantaged children. Two key "predictors" of educational success were related to educational supports in the home. First, children from families where the mother was a high school dropout were much less likely to graduate from high school themselves. Second, while economically disadvantaged children learned at the same rate as other children during the school year, their greater "learning loss" over the summer resulted in their falling further and further behind.(1, pp. 35-38) The implication of Berlin and Sum's analysis is that achieving educational success with disadvantaged youth requires work with support structures of parents and communities, as well as work within the school system.

Schorr's and Berlin and Sum's books are only two examples of influential works that have stressed the need for more collaboration and service coordination among different state programs and a more family-centered focus in designing interventions that are capable of crossing bureaucratic and professional lines. While actual collaboration and service must occur at the local service delivery level, states can play a key role in facilitating and directing this action. Collaborative and cooperative agreements, the provision of case management services, and the development of new, interdisciplinary program models can address the needs of families with multiple needs better and avert the rotten outcomes that those families and society can ill afford.

Federal Policy

Most federal programs follow categorical funding lines. For instance, Medicaid, one of the largest federally funded programs administered by the states, involves extensive regulations and restrictions that generally prevent the substitution of nonmedical services for medical ones or of home-based services for hospital-based ones. Child welfare funds available through Title IV of the Social Security Act for foster care services generally can be used to pay for out-of-home placements but not for services to prevent placement. Federal mental health and substance abuse treatment funds and federal welfare funds cannot be intermingled. However, the federal government has begun to consider providing support for multidisciplinary approaches to meet the needs of low-income families.

The successful and popular federal Head Start program, which provides preschool programs to at-risk children and their families, stresses educational, health, and social service support. Begun in 1965, Head Start now serves more than 450,000 children nationwide. It requires parental support and participation in program activities. Health and nutrition services and social services are offered in addition to educational programming.

In 1985 Congress added Section 1915(g) to the Social Security Act to allow states to provide case management services to Medicaid-eligible individuals to "gain access to needed medical, social, educational, and other services." Unlike most Medicaid services, case management need not be offered to all Medicaid-eligible clients nor as a statewide service. Special populations may be designated for case management services, and states are given wide discretion in defining case management for each population. This case management is a connecting and coordinating link between different service providers and Medicaid clients. The matching federal funds available for case management under Medicaid have induced a number of states to develop systems to coordinate different client services.

Under the Family Support Act of 1988, states are required to implement an education and training program (JOBS) for a much broader number of AFDC parents and to assist younger AFDC

parents in completing high school or obtaining GEDs. Daycare must be provided, child support enforcement efforts intensified, and extended child care and medical benefits offered to those who find jobs that disqualify them for cash assistance. To develop effective welfare reform programs, states need to have greater communication among welfare agencies, employment and training agencies, daycare and other local providers of service, and public schools.

Some federal programs simply have mandated interagency councils as a prerequisite for receiving federal funds. New federal special education legislation under the Education for the Handicapped Amendments of 1986 (P.L. 95-457) requires states to establish an interagency council to develop a statewide coordinated system for early intervention as a condition to receiving federal funds for early intervention programs for infants and toddlers with handicapping conditions. The Stewart McKinney Act, which provides funds for programs to assist the homeless, also requires interagency planning as a condition for obtaining federal support. The National Institute of Mental Health requires similar interagency cooperation for states receiving CASSP grants.

Finally, the federal government has initiated a variety of special grant programs designed to support more comprehensive services for families. The Comprehensive Child Development Centers Act of 1988 makes $19.1 million available in each of the next five years for between 10 and 25 local programs to provide comprehensive services to low-income pregnant women or families with infants. These comprehensive services include prenatal services, parenting support, and assistance in job skill development. The programs are designed to improve both child development and the economic outlook for the families served.

The Community Services Block Grant (CSBG) program was created by the Omnibus Budget Reconciliation Act of 1981 with the purpose of ameliorating the causes of poverty through support of a range of local services including employment, education, housing, emergency assistance, and nutrition. In 1987 Congress appropriated a total of $400 million for the CSBG program, $335 million of which consisted of block grants distributed through the states to local community action agencies. Another $36.6 million was distributed to the states for emergency homeless assistance.

State Policy

Integrating services for families with multiple needs requires a much greater emphasis upon collaboration, exchanges of information, and service coordination at all levels of government. States are responding to this challenge in a number of ways. First, several states have developed special structures within their legislative systems to coordinate approaches in developing legislation affecting children and families. Second, a wide variety of interagency task forces or commissions have been established to seek greater coordination among state agencies dealing with families. Third, case management programs have been developed to provide a means, at the service delivery level, to integrate existing services available to families across a variety of agencies or professional specializations. Fourth, states have funded innovative programs designed to achieve multiple program objectives or outcomes by dealing with families through specific, inclusive programs. Finally, states have reconfigured the way that they finance programs for children and families to provide a family-centered service delivery system, rather than one based on separate funding streams.

Legislative Structures to Coordinate Family-Oriented Legislation. Within the legislature itself, state legislators can facilitate collaborative efforts in their examination of public policy issues affecting the family. Many actions consist of informal relationships among key committee chairs or ad hoc meetings of select legislators on specific issues, but some are more formalized. Several distinctive approaches to developing a legislative focus on collaboration are the following:

- Eight states have established select committees on children and youth. In Tennessee, the legislative chairs of the major committees responsible for children and youth legislation comprise a particularly effective select committee, which has been able to establish policy

goals that are then pursued by committee members across the various standing committees within the General Assembly.

- Focusing explicitly on family issues, the California Assembly established and funded a Joint Select Task Force on the Changing Family, which involved a wide array of legislators and community and business leaders, that issued its first yearly report in 1989. This report contained policy recommendations on a wide array of family issues, including intergenerational approaches to family problems to avoid pitting the young against the old in setting social policy.

- Twenty states now have standing committees on children and youth. Missouri's House has established a standing committee, the Children, Youth, and Families Committee, to consider the comprehensive needs of families relating to health, social welfare, child welfare, and education.

Interagency Task Forces and Commissions. In addition to restructuring the legislative system to better address family concerns that cross legislative jurisdictional lines, states have developed interagency task forces, commissions, or other structures linking executive departments to encourage coordination and reduce duplication of service efforts. These task mechanisms are generally more successful at achieving their objectives if they are provided with some financial backing, given some rule-making authority or control over individual agency actions, or given the responsibility of awarding grants and overseeing programs that require collaboration.

A 1989 publication from the National Association of State Boards of Education, *Joining Forces*, identified 195 state-level collaborative task forces/committees, agreements, or initiatives from 47 states and two territories.(3) Collaboration generally involves social services, welfare, public health, and education state agencies, and often includes the departments of law enforcement, mental health, and job training. States most frequently cited the following issues for cooperative action: general task forces or commissions on children and youth (18 states), drop-out prevention (18 states), adolescent pregnancy and parenting (15 states), at-risk youth (12 states), child abuse and child welfare (11 states), early childhood education (10 states), actions mandated by P.L. 95-457 in order to receive federal funds for special education services for infants and toddlers with handicapping conditions (19 states), emotionally disabled (18 states), welfare reform (7 states), and the homeless (4 states). The interagency office was sometimes given greater control and responsibility for some issues.

- In 1983 Delaware created the Department of Services for Children, Youth, and Their Families that brought into a single department child protective services, child mental health services, child and youth diagnostic services, and youth rehabilitation services. The department plans and provides direct services for children, youth, and families.

- With nearly $3 million annually, the New York Council on Children and Families is designed explicitly to ensure the coordination of social, educational, mental health, and other supportive services to children and families across state/local and public/voluntary systems. The council does not operate programs but seeks to coordinate and integrate existing programs and services.

- In 1988 the Michigan Human Services Cabinet Task Force on Youth Services, representing seven departments and the governor's office, was created to review current agency responsibilities, develop principles for a model delivery system, designate services that should be administered by a single agency, and recommend a consolidated funding strategy. California has legislation pending to establish the Interagency Children's Services Coordinating Board to develop a comprehensive and collaborative delivery system that emphasizes prevention and early intervention services, allows flexibility in the

expenditure of funds, emphasizes local decision making, and minimizes duplicative administrative services.

- In 1987 Nebraska established an intergovernmental and community planning process to develop a state plan for achieving a public policy to strengthen families, with funding for family preservation teams provided for local programs.

- In 1988 Oklahoma established the Child Deaths Task Force to examine child fatalities and recommend ways to reduce them. Maine had established a similar task force in the early 1980s that focused attention on the greater risk of death that low-income children faced from all causes. Maine's task force gave impetus to a wide-ranging number of health, human service, and educational initiatives designed to reduce this risk.

- As part of a larger drug enforcement bill, Iowa established the Youth 2000 Interagency Commission in 1989, centered in the Department of Education and designed to develop school-based interdisciplinary efforts to provide youth with positive options to drugs.

- Other multiagency approaches to helping families include: Delaware in 1986 established the Governor's Commission on Work and the Family to develop policy recommendations; Wisconsin in 1985 established a Youth Suicide Prevention Council; the Virgin Islands in 1987 established the Task Force on Sexual Abuse; and Michigan in 1986 created the Interagency Committee on the Black Child.

Case Management Approaches. Done effectively, case management can be a valuable tool to coordinate the delivery of existing services to families and to access additional services to meet family needs. With new flexibility created by changes to the Medicaid program, a number of states have found creative ways to develop case management services for children and families and draw down matching federal funds. States now can provide a broad range of nonmedical services that traditionally have not been eligible for reimbursement under Medicaid. Among many interesting state initiatives, the following are considered among the most comprehensive:

- As a pilot project, California established an obstetrical outreach and access program in 1983 for low-income pregnant women with an expanded array of services, including nutritional counseling, psychosocial assessment, and case management and supervision to ensure continued prenatal care. This outreach and access program was expanded statewide following the results of a study that showed a savings of nearly $2 in reduced neonatal intensive care costs for every $1 expended on the program.

- Nineteen states currently provide coordination and case management under a Medicaid-enhanced prenatal services program, with 16 providing nutritional counseling as a program component; 11 providing psychosocial counseling, and 11 integrating home visits. As one of those states, Arkansas provides services that include risk assessment, case management, perinatal education, social services consultation, nutritional counseling, and early discharge home visits. Of particular interest in the Arkansas program is the provision of up to six classes of perinatal education and the early discharge home visit. The expanded services can be provided by a physician or by referral to a local county health unit.

- Vermont has recently developed a broad-based initiative to provide Medicaid case management services to seriously emotionally disturbed adolescents who require multiple services and has linked this case management to local interagency teams to ensure that the full needs of the children are being met. Although funded by Medicaid, the case management providers do not have to be medical care professionals, and service delivery can be provided in the home or community. Vermont's use of Medicaid helped extend the

Children and Adolescent Service System Program (CAASP), undertaken in the state as part of a National Institute of Mental Health project to promote the development of state and local services for seriously emotionally disturbed children. CASSP programs, which require multiagency coordination, operate in a number of states.

- Wisconsin has used the targeted case management service option to serve physically disabled, developmentally disabled, alcohol- or drug-dependent, and seriously emotionally disturbed children and to provide assessment, case plan development, and service coordination, with eligible providers representing a variety of disciplines.

- Following a nine-county pilot program of case management for pregnant and parenting teens, New York implemented a statewide program of case management services to Medicaid-eligible pregnant and parenting teens. The Teenage Services Act (TASA) case management program requires local service districts to offer case management to adolescents who are under 18 years old, receiving AFDC or home relief, and pregnant or a parent. At their discretion, local districts may offer case management to teens at risk of becoming parents. The case management services are designed to help the adolescent obtain needed services and assistance, with an emphasis upon developing a plan to become self-sufficient. Specific case management activities include outreach and identification of eligible youth; assessment with the client of his or her needs and capabilities; the development of a plan and goals; assistance with services, including identification, referral, and brokering; re-evaluation of the goals and plan; and networking with other agencies.

Innovative, Multiple-Objective Programs. While delivery of service to families through case management is important, actual coordination and collaboration ultimately occur at the state level. A number of new state initiatives have emerged that have provided state funding to local organizations to encourage collaboration in program design and retain program ownership at the local level.

- With the help of private foundations and a significant state financial commitment, Maryland has established 11 Family Support Centers that serve as drop-in resources for pregnant and parenting teens. These programs seek to provide support that participating teenagers need, including respite child care, educational and job counseling, parenting support, self-esteem building, and health services, with referral to other agencies for more specialized services. Initial analysis suggests that the centers have been effective in reducing the incidence of subsequent pregnancies, reducing child abuse, improving child development, and improving school completion.

- Many states are supporting local community development corporations (CDCs) to create housing and job opportunities in distressed communities. The Massachusetts Executive Office of Communities and Development provides loans and technical assistance to CDCs, coordinates access to federal grant funds, oversees local community action agencies in their antipoverty efforts, oversees a job corps, provides weatherization and energy assistance, and supports community-based commercial development.

- In 1988 the New Jersey Department of Social Services committed $6 million to establish school-based youth services programs in middle and high schools plagued by multiple teenage problems. While the state mandated that programs provide health, mental health, and family counseling and employment services, local communities were given control and ownership of the programs. Grant applications require the support of local organizations, the school, the private industry council serving the area, and the parent-teacher association. However, the community designates the lead agency in program delivery.

- Missouri in 1989 established two sites, one urban and one rural, as "Caring Communities," with the coordination of comprehensive education, health and mental health, and social services. Such services include: latchkey programs, universal Head Start, adult basic education, school nurse services, crisis intervention services, day treatment for troubled youth, alcohol and drug abuse services, and elementary school counselors. With private foundation support as well as state funds, Missouri will spend over $1 million in new funds to enhance services and to provide community project coordinators at these sites. Goals of the Caring Communities programs are to succeed at keeping at-risk children in school, in their own homes, and out of trouble with law enforcement authorities.

- In the context of welfare reform and under the direction of a multiagency council, Iowa funded seven grant programs in 1988 to provide "family advocate" services to AFDC families judged to be at risk of long-term welfare dependency because of education, work history, and family structure. Programs are to be evaluated on multiple measures, including job earnings and educational attainment, child development and health, and avoidance of the foster care or juvenile justice system. The family advocate coordinates services for clients and works with them on developing self-sufficiency goals.

- For more than a decade, Texas has operated the Communities in Schools program, a state-supported adaptation of the Cities in Schools models, which brings one-on-one counseling services into schools to work intensively with students identified as at risk of dropping out. The Arkansas Project, Services Provided to At-Risk Kids (SPARK), provides training for school counselors on behalf of at-risk children through funding provided by a consortia of the Departments of Education, Employment and Security, Vocational Education, Mental Health, Child and Family Services, and Alcohol and Drug Prevention.

- Washington state's school-based Primary Intervention Project (PIP) provides similar services to detect and address the social and emotional problems of children in kindergarten through third grade and to prevent later learning difficulties. Washington's program is operated through the Mental Health Division of the Department of Social and Health Services and is designed to detect and intervene in problems such as verbal and physical aggressiveness, low self-esteem, withdrawn behavior, and social and emotional immaturity. It also serves children who are victims of abuse and neglect or who have experienced family problems such as death or divorce. Washington's PIP is similar to programs in California and Connecticut and is based upon the Primary Mental Health Project that has been in operation in Rochester, New York, since 1958.

- Through the Community Schools Task Force, New York has established a grant program to assist elementary schools become the base for the provision of a wide range of community services, including child care, adult education, senior citizen support, and recreation services. "Community centers" will be created to stabilize communities that otherwise may disintegrate.

Refinancing Service Delivery to Families and Children. An even more ambitious approach than greater service coordination through case management or specific local projects with multiple goals is an approach to redesign service delivery systems through restructuring and redirecting existing funds. This refinancing is designed to change the way that service providers view families and to provide a more holistic and community-oriented focus to service delivery. The theory behind this strategy is that investment in prevention and early intervention services will reduce high social service costs in the future.

- With major funding support from the Annie E. Casey Foundation, Maryland and North Dakota are developing interagency model funding programs for addressing the needs of

at-risk families. The intent of the programs is to review current funding systems for child welfare within the states and to reshape financing of child welfare services to emphasize community-based early intervention and prevention.

- In 1988 Iowa designated two counties, representing 15 percent of the state's population, for a special "decategorization" project. In these two counties, beginning July 1, 1989, a single state appropriation for child welfare services was made, representing county receipts from 32 separate funds, including foster care, juvenile detention, protective daycare, in-home services, departmental protective service staff, institutional mental health and retardation services, and juvenile training school funds. Within the county, the Department of Human Services, the County Board of Supervisors, and the juvenile court decide allocation of funds and are not bound by eligibility standards or departmental rules regarding fund distribution. Initial plans in the counties are to enhance family preservation services, develop additional services to avoid the need for costly out-of-home placements, and provide workers flexibility in providing "wrap-around" services, on a case-by-case basis, for services ineligible under general state funding restrictions.

- At legislative direction, Ventura County, California, has operated the Ventura Model for Interagency Children's Mental Health Services since 1985. This model seeks to provide a broad continuum of services to children with mental problems who might enter the system through the juvenile court as juvenile offenders, through the juvenile court as children in need of assistance, through the special education system, or through social service agencies. The model includes an interagency case management council and shared responsibility by the Departments of Mental Health, Social Services, Corrections, and Education. By focusing upon early intervention services, coordination of care, identification of family unity, and local treatment, the model will avoid costly institutional placements and recidivism for overall systemic cost savings. The model has been widely studied for replication throughout California and in other states and communities.

Clearly, there is no one model for developing greater collaboration in the provision of services to families and children with multiple needs. Programs working with specific populations or with children of specific ages can be successful. The common denominator, however, appears to be the involvement of the family in establishing goals that are flexible in meeting its needs. Availability of adequate resources to meet these needs is also critical.

Key Points

In examining means to integrate service delivery to meet fully the multiple needs of families or to address family needs better in multineed communities, the following points need careful consideration in the development of sound public policy:

- When a variety of risk factors exist for a family, the likelihood of rotten outcomes occurring within that family increases dramatically.

- Communities, as well as families, can be targeted for interventions that seek to coordinate support services. Throughout the country, geographic areas can be identified that have extremely high proportions of high school drop-outs, welfare recipients, female heads of household, and working-age males not regularly participating in the labor force. Such areas demand comprehensive, community-wide approaches to avert rotten outcomes for the individuals in those communities.

- Flexibly designed programs focusing upon one specific population and service, such as parenting programs for teenagers, may achieve a variety of positive results, including

reduced welfare dependency, reduced likelihood of subsequent pregnancy, increased high school completion, avoidance of substance abuse, improved child health and development, and reduced child abuse and use of the foster care system. Program evaluation on a variety of dimensions that cross specific agency boundaries may be essential to ensure maximum program effectiveness.

- The manner in which the state finances and regulates programs and services directly affects the ability to coordinate services for families. In particular, rigid categorical funding streams can serve as a major obstacle to meeting family needs by inappropriately serving families and producing fragmented and conflicting family interventions.

- Interagency collaboration and coordination can be encouraged by providing incentives to collaboration and by increasing staff time and resources. Efforts at collaboration are most likely to be successful when individual agencies or departments are held responsible for collaborative efforts.

- Collaboration ultimately occurs at the local level and is the result of people working together. The extent of collaboration depends upon the degree to which individual local agencies value interagency work and provide support and time for staff to engage in such efforts.

Recommendations for State Action

The NCSL Children, Families, and Social Services Committee recommends the following state legislative action to improve the quality of services to families with multiple needs:

- Identify communities or areas within the state where a variety of child and family risk factors exist and consider such communities for possible targeting of additional support services, while identifying basic needs to make those services effective.

- Identify the types of families with multiple needs for whom the current system of service delivery is not working and seek to involve the different agencies and professions working with such families in developing systems to meet those families' needs better.

- Identify the state funding sources currently available to serve families and the overall expenditure of state funds for children and family services, using this information as a basis for evaluating the need for collaboration among different programs and the degree to which current funding sources and categorical funding streams are in potential or actual conflict with one another.

- Where collaboration at the local level is desired or necessary, develop state systems that can help local entities retain ownership over programs.

- Seek to review and evaluate programs designed to work with families with multiple needs on multiple outcome measures. It may be that the effect of programs will be seen differently in different families and that seeking a single program outcome will not achieve the desired impact.

- Identify the means that reduce barriers to interagency coordination, such as co-locating agencies.

- o **Provide sufficient authority, responsibility, and funding for interagency commissions to enhance their effectiveness in achieving their goals. This may require displacing power from individual agencies.**

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APPENDIX A

1988 NCSL Children, Families, and Social Services Committee

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APPENDIX B

1989-90 NCSL Children, Families, and Social Services Committee

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Representative Beverly Stein

Rhode Island
Representative Nancy Benoit
Senator John Reed
Senator David Sholes

South Dakota
Representative Jean Beddow

Texas
Representative Erwin W. Barton
Senator Chet Brooks

Vermont
Senator Stephen Blodgett

Washington
Representative June Leonard
Senator Linda Smith
Senator Lois Stratton

Wisconsin
Senator Carol Buettner
Senator David Helbach
Representative Rebecca Young

Tennessee
Senator Riley Darnell
Speaker Lois DeBerry

Utah
Representative Melvin Brown

Virginia
Senator Edward Holland

West Virginia
Senator Robert Holliday
Senator Charlotte Pritt

Wyoming
Representative Richard Honaker

APPENDIX C

Acronyms

AARP	American Association for Retired Persons
AFDC	Aid to Families with Dependent Children
AFDC-UP	Aid to Families with Dependent Children-Unemployed Parent
AFSCME	American Federation of State, County, and Municipal Employees
AHCCCS	Arizona Health Care Cost Containment System
AIDS	acquired immune deficiency syndrome
ASPIRE	Additional Support for People in Retraining and Education
CASSP	Children and Adolescent Service System Program
CCC	Civilian Conservation Corps
CDBG	Community Development Block Grant
CDCs	community development corporations
CETA	Comprehensive Employment and Training Act
CFSS	Children, Families, and Social Services Committee
CHIP	Catastrophic Health Insurance Plan (Rhode Island)
CPS	child protective service
CSBG	Community Services Block Grant
CSDD	Community Services for the Developmentally Disabled (Michigan)
CSP	Community Support Program
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
ECFE	Early Childhood Family Education (Minnesota)
ECIA	Education Consolidation and Improvement Act
EEC	European Economic Community
EIA	Education Improvement Act
EPSDT	early and periodic screening, diagnosis, and treatment
FAS	fetal alcohol syndrome
FEMA	Federal Emergency Management Agency
FIP	Family Independence Program
FPL	federal poverty level
FY	fiscal year
GAO	General Accounting Office
GED	General Education Degree
HCG	Health Care Group (Arizona)
HHS	Health and Human Services
HIPPY	Home Instruction Program for Preschool Youngsters (Arkansas)
HIV	human immunodeficiency virus
HMO	Health Maintenance Organization
HOME	Housing Opportunities for Maine
HUD	Housing and Urban Development
IFS	Intensive Family Services
IOM	Institute of Medicine
IPO	Improved Pregnancy Outcome (Florida)
IV	intravenous
JCY	Jobs for Connecticut Youth (Connecticut)
JOBS	Job Opportunity and Basic Skills
JTPA	Job Training Partnership Act

MCH	Maternal/Child Health
NAHRO	National Association of Housing and Redevelopment Officials
NCPIE	National Coalition for Parent Involvement in Education
NCSL	National Conference of State Legislatures
NIDA	National Institute on Drug Abuse
NIMH	National Institute of Mental Health
OTJ	on-the-job (training)
PACE	Parent and Child Education Program (Kentucky)
PAT	Parents as Teachers (Missouri)
PATH	Partnerships to Aid the Homeless (Maine)
PATHS	Partnerships to Aid the Homeless (Minnesota)
PCC	Parent-Child Centers
PIC	private industry council
PIP	Primary Intervention Project (Washington)
R&R	resource and referral
REACH	Realizing Economic Achievement Program
SBHCs	School-Based Health Clinics
SDA	service delivery area
SJTCC	State Job Training Coordinating Council
SPARK	Services Provided to At-Risk Kids (Arkansas)
SSBG	Social Services Block Grant
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STEP	School to Employment Program (New York)
TASA	Teenage Services Act (New York)
TFC	Together for Children (Oregon)
TIP	Tuition Incentive Program (Michigan)
UCCJA	Uniform Child Custody Jurisdiction Act
WIC	Women, Infants, and Children
WIN	Work Incentive Program

The National Conference of State Legislatures

Human Services Department

The NCSL Human Services Department is designed to meet the needs and interests of state legislatures in developing human services policy and program issues. Legislators are involved in every aspect of state human services policymaking, including: intercepting federal funding, establishing laws, reviewing agency budgets, setting performance standards, creating programs, and providing guidelines for judicial proceedings. In the present climate of fiscal scarcity and shifting responsibilities between the federal and state governments, state legislatures have become a focal point for determining human services policy and program priorities.

The department provides a broad array of services to state legislatures on the continuum of human services. Particular expertise has been established through the Children, Youth, and Families Program and the Health Services Program in the following areas: child welfare, child support enforcement, child care/early childhood education, teenage pregnancy, AIDS, child/maternal health, mental health, developmental disability, substance abuse, domestic violence, health care cost containment, long-term care, and the medically indigent.

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